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STATE OF MONTANA

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

CHANNELING DEMONSTRATION PROPOSAL

Technical Proposal

Montana's response to RFP-74-80-HEW-OS
National Long-term Channeling Demonstration

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DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

THOMAS L. JUDGE, GOVERNOR

P O BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59601

June 10, 1980

Mr. Scoville, Contract Specialist
Department of Health and Human Services
OS, Division of Contract and Grant Operations
Room 443 H
H.H. Humphrey Building
200 Independence Avenue, Southwest
Washington, D.C. 20201

Dear Mr. Scoville:

I am pleased to submit this proposal in response to the National Long-Term Care Channeling Demonstration request for proposals (RFP-78-80-HEW-OS) on behalf of the Governor and the state of Montana. As indicated in Governor Judge's letter to Secretary Harris, dated June 3, 1980, the Montana Department of Social and Rehabilitation Services is the designated lead agency for this project, and I am the authorized signator.

The proposal was prepared in conjunction with the project management team which is proposed to provide day-to-day management guidance to the project once it is operational. The principal authors are Gary Blewett and Jack Dorner. Both are employed in the Medical Assistance Section of the department. Mr. Blewett is in charge of preparing the Medical Assistance budget and for managing reimbursement for nursing homes. He is also the Governor's representative on the State Health Coordinating Council and the Montana Health Systems Agency. Mr. Dorner supervises policy direction for the nursing home prescreening program, and coordinates with the Montana Foundation for Medical Care.

All certifications required for this proposal have been signed and are included in Appendix K.

This proposal will remain valid for a period of ninety (90) days from receipt. Technical questions arising during your evaluation should be addressed to Gary Blewett at (406)449-3952.

Very truly yours,

Benjamin F. Johns

Keith L. Colbo
Director

cc Gary Blewett
Jack Dorner

"AN EQUAL OPPORTUNITY EMPLOYER"

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PROPOSAL FOR
MONTANA LONG-TERM CARE CHANNELING DEMONSTRATION

2. EXECUTIVE SUMMARY

During the past year the State of Montana has been in the process of developing a long-term care plan for the elderly. A multi-agency task force was formed in May, 1979, to prepare a request-for-proposals from qualified consultants to research the literature in the area of long-term care, estimate the need for long-term care among Montana's elderly, and to estimate the cost of meeting that need. The firm of JRB Associates, Inc. was selected to conduct this study of alternatives for long-term care. The final report for this study will be completed by July 31, 1980. Interim reports from the study effort are enclosed with this proposal and inform the estimate of need among Montana's elderly used in the proposal.

It has been the State's intention to follow-up the study with a long-term care plan, which would be prepared by an expanded LTC task force. The opportunity to submit this proposal for a channeling demonstration has almost coincided with the State's schedule for moving forward with the preparation of the LTC Plan. The State's own agenda has been to put a plan together that would initially be of benefit during the upcoming session of the Montana State Legislature, which convenes on January 2, 1981, for a ninety-day session.

Montana will still do that, but in the context of this proposal, that effort will be an interim LTC Plan, focusing on legislative proposals and State budget considerations. Should Montana be selected as a contractor, the opportunity to further develop this plan is moved up from what the State would otherwise be able to do. Moreover, the opportunity to have a demonstration site to work with and work out the problems to be faced in implementing such a plan will make the plan valid and useful elsewhere.

Integral to this effort is the establishment of the Long-Term Care Planning Group. The Governor is establishing a group that draws membership from several State agencies and other agencies with interests and responsibilities in the area of long-term care. This group is being formed from the nucleus that currently exists as the task force to study alternatives in long-term care. This task force is made up of representatives from the following Montana agencies:

- Department of Health and Environmental Sciences (the designated State Health Planning and Development Agency)
- Department of Social and Rehabilitation Services (lead agency for this proposal and agency responsible for Titles III, XIX, and XX)

. Department of Institutions (responsible for Comprehensive Mental Health Services and Community Mental Health Centers)

. Montana Health Systems Agency, Inc. (the designated HSA for Montana)

. The Governor's Office

The expanded group will be chaired by Mike Miles, Special Assistant in the Governor's Office. In addition to the prior task force membership, the LTC Planning Group will be expanded to include SRS's LTC Project Management Team and a representative from the Governor's Office of Budget and Program Planning.

The Administrator of the Federal Government's Health Financing Administration will appoint the Region VIII Director of HCFA to represent the Medicare program on the group. The ten-member group will be assisted by a resource group of consumer, provider, and funding agencies and organizations. The resource group will be available for consultation and input as long-term care issues raised by the channeling demonstration may require.

The project will be administered by the Department of Social and Rehabilitation Services, which is the agency responsible for administering the Title III, XIX, and XX programs. A project management team has been organized to prepare and review this proposal. Should Montana be awarded a contract, this team would function as a vehicle for day-to-day coordination and review of project management. In addition to SRS's Deputy Director for Program and Planning, Judith Carlson, who chairs the team, the Project Management Team has three members who have administrative responsibilities for Titles III, XIX and XX.

The project will be staffed at the State level by a manager who will be a member of the SRS Director's Office, and who will report to the Deputy Director. A half-time secretary will assist the manager. Consultant services will be retained to work on site planning during the first two months following contract award, to develop the screening instrument based on the Geriatric Functional Rating Scale used in the State's alternatives study, to assist in the development of the management information system, and to provide analyses relevant to the state-of-the-art assessment for long-term care planning. SRS will also contract with the Montana Foundation for Medical Care, the PSRO for the state, to conduct periodic audits and program reviews of channeling services rendered demonstration site recipients.

SRS will subcontract with the lead agency for one of the two proposed sites for demonstration channeling services. The proposed sites are based in the communities of Anaconda and Missoula and would include their surrounding counties. The catchment area for the Anaconda site has an estimated 1980 population of 84,451, of which 70% are located in or very near

Anaconda or Butte, the area's largest community. Initial estimates for the elderly target population, based on GFRS survey results, is that the number could range from 1,019 clients to a low of 488 clients. The catchment area for the Missoula site has an estimated 1980 population of 94,348, of which 75% are located in or very near Missoula, the 3rd largest city in Montana. Estimates for the elderly target population ranges from a high of 653 clients to a low of 303 clients. All projections of resource requirements used in the proposal were based on the low estimates.

The proposed channeling agency for the Anaconda site is the Montana Area V Agency on Aging, which is a non-profit organization charged with the responsibility for planning services for the elderly in a six-county area that includes the cities of Anaconda and Butte. The proposed channeling agency for the Missoula site is the Missoula County Council on Aging, a non-profit organization which administers, plans for all aging funds allocated to the county. The Missoula Council proposes to subcontract channeling service responsibilities to the Missoula City-County Health Department.

Whichever site the government chooses for the demonstration, the staffing and method of organizing for channeling will be the same for both sites. The various service opportunities and local circumstances will cause the implementation of delivery to vary, however. A site will be administered by a manager who is hired by the channeling agency. A full-time secretary will assist the manager. One screener will screen all referrals from the area health/social service network, using an adapted version of the GFRS. Cases that pass the screen for channeling services will be assessed by a nurse/social worker team, who may call in a consulting physician or other specialists if indicated. The cases that become channeling clients will be managed on an on-going basis by a social worker, who will track the client against the plan of care developed during the assessment. Clients will be reassessed either as a result of crisis intervention or, at a minimum, every six months. The channeling agency's assessment/case management team will be staffed with one nurse and four social workers.

SRS is proposing an alternate to do an 18-month follow-up survey of the sample used to identify the number of functionally impaired elderly in Montana, using the GFRS. The initial survey was conducted between January and May, 1980, and includes one thousand respondents who form a unique baseline of noninstitutionalized, randomly selected community aged. We propose following these respondents at one year intervals throughout the life of the demonstration. The alternate would involve one person year of consultant time for each of four years.

This proposal is predicated on the availability of the national technical assistance contractor for training in the use of the assessment instrument and case management definitions and procedures to be developed by the national evaluation contractor. SRS is prepared to work closely with and cooperate with both

contractors, but place a condition on our involvement to the extent that all demands made on the local channeling agency be scheduled in advance with proper notification to both SRS and the local agency. SRS will also cooperate with the proposed randomized assignment of channeling applicants to experimental and control groups, provided that the control group selection is separated from the experimental group by either geographic or eligibility criteria, and that SRS is allowed to participate with the national contractor in developing the sampling design. SRS cannot allow an applicant, who is otherwise eligible for services that are proximately available, to be denied those services because of the draw of a random number.

Problems that may be encountered with the Montana channeling demonstration concern the availability of services in the proposed sites. In both areas there is evident demand for more channeling alternatives. In both areas there are unoccupied nursing home beds; in the Anaconda area due to a declining population; in the Missoula area due to shifts in placement caused, in part, by the SRS prescreening program. For channeling to work, seed money for expanding services is essential right along with the staff to conduct channeling responsibly. SRS has proposed using the full $250,000 limit during Phase I and the additional amounts indicated in the RFP for the remaining years to allow for this service expansion. The justification can be better detailed following receipt of our final report on alternatives. However, the conditions in each area are clear that the Montana demonstration must be predicated on receipt of expansion funds. The State is committed to investing these funds as seed money, not for continuing dependency past the life of the demonstration.

3. BACKGROUND INFORMATION ON MONTANA

3.1 Description of the Demographics of Montana - Montana is a rural state encompassing large, sparsely populated areas. Montana has a population of 785,000 residents spread over the state's 145,319 aquare miles, resulting in a population density of 5.4 persons per square mile. Indians, as of 1970, comprised 3.9% of Montana's population. Montana is a multi-faceted state when it comes to land and climate. High plains are found in the eastern three-fifths of the State. This land, unprotected against extreme temperature changes, is used for dryland farming.

Western Montana is an opposite extreme more than just georgraphically. It is filled with timber, mountains and scenic wonder. It includes most of Montana's 22.7 million acres of forest land where most of the State's timber production takes place. The continental divide, along the upthrust of the Rockies, provides protection from the extreme cold of the eastern plains, giving western Montana milder winters. Glacier National Park is in the northwestern corner of the State. Its western ruggedness forms the backdrop for a major part of the hunting and fishing which takes place in the Treasure State and brings in excess of $200 million a year in tourism.

Running through Montana are the rivers which are tapped to provide water to irrigate the fields and grazing lands of the state. The Yellowstone and Missouri Rivers, along with the Fort Peck Dam and Reservoir, dominate the eastern region while several small rivers course through the mountain forests of the west. Montana has 31,631,494 acres of grazing lands which sustain the important livestock portion of the agricultural industry.

Much of Montana's economy is supported by government employment and contracts. Major revenues come from federal money spent to run defense and other government facilities in the State. Agriculture is the main industry in Montana. The State's Great Plains region produces the third largest amount of wheat in the nation.

Mineral production, chiefly copper and petroleum, contribute measurably to the economy. Much of the west's strippable coal reserves are in Montana -- an estimated 15 to 20 million tons -- causing activities associated with energy development to become increasingly important. Perhaps largely as a result of this

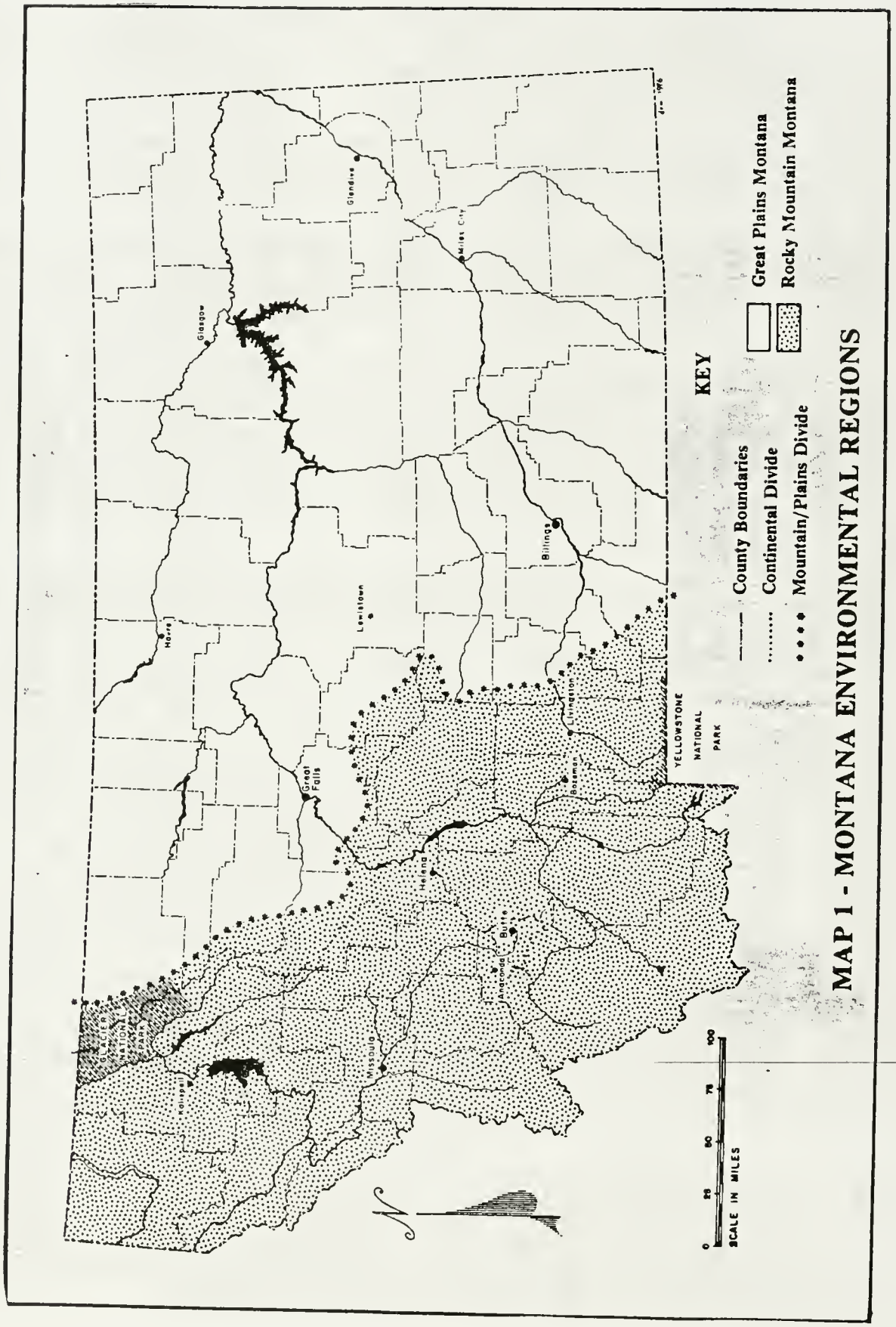
energy expansion, the population declines of the 1960's have stopped and the population of most counties has increased or remained fairly stable since 1970.

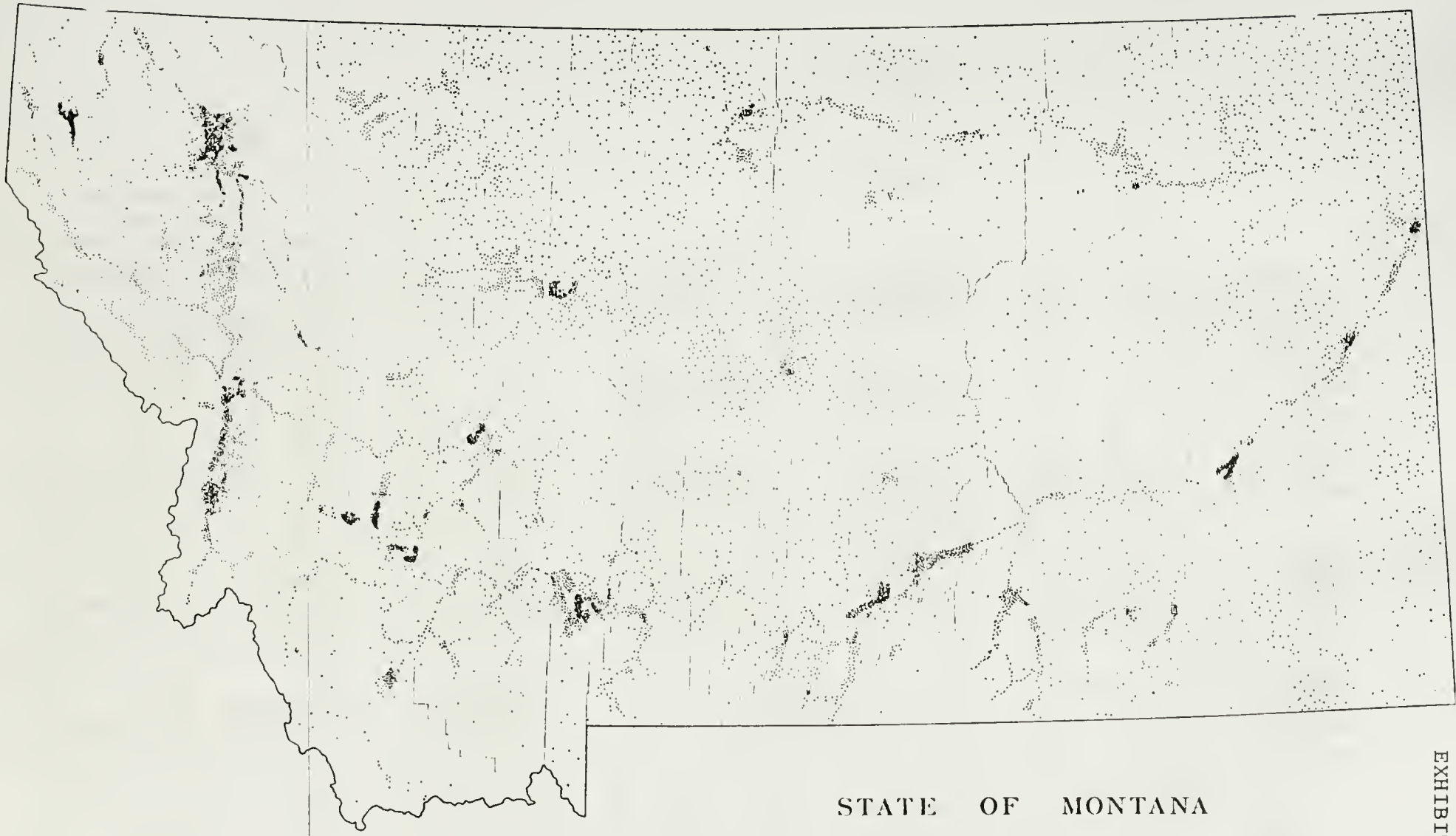
A map showing Montana's environmental regions is presented as Exhibit 3-1. Population dispersion is presented in Exhibit 3-2.

3.2 Overview of State Organizational Structure for Long-Term Care in the State of Montana - Montana has nineteen (19) State level departments organized under the direction of the Governor's office and three other elected officials. Of these nineteen, six (6) departments have divisions, bureaus or units providing services to the elderly. A brief description of each relevant agency currently supporting long-term care in the State of Montana is presented as Appendix A. Exhibit 3-3 presents the organizational structure of these agencies. Appendix H presents the organizational chart of Montana Social and Rehabilitation Services.

3.3 Summary of the Characteristics of the Target Population and Evidence of Their Need for Long-Term Care

In June, 1979, the Montana Department of Health and Environmental Sciences contracted with JRB Associates, Inc., to conduct a study on the cost of alternatives to nursing home care for the elderly and mentally handicapped. This contract was a result of a Task Force formed to recommend legislative and budget considerations for the 1982-1983 biennium regarding the necessary support and care of the elderly and mentally handicapped in Montana. The Task Force represented the spectrum of state agencies concerned with long-term care, including the Governor's Office, Social and Rehabilitation Services, Health and Environmental Sciences, Institutions, and Health Systems Agency. The Task Force wanted to know, among other things, how many people in Montana need assistance to support a relative degree of independence, short of institutionalized care. The study is due for a completion date of July 31, 1980. The preliminary data has been presented, however, identifying channeling candidates residing in Montana. A detailed description of this study is appended presenting information on survey methodology and administration (see Appendix J). It is important to note here that the survey utilized Grauer and Birnbom's "Geriatric Functioning Rating Scale", an internationally recognized instrument for predicting the need for long-term care services.


MAP 1 - MONTANA ENVIRONMENTAL REGIONS
KEY
Great Plains Montana
Rocky Mountain Montana
County Boundaries
Continental Divide
Mountain/Plains Divide
SCALE IN MILES
0
25
50
75
100
Glasgow
Glendive
Miles City
Billings
Havre
Lewistown
Great Falls
Helena
Butte
Anaconda
Missoula
Kalispell
Livingston
Bozeman
YELLOWSTONE NATIONAL PARK
GLACIER NATIONAL PARK



STATE OF MONTANA

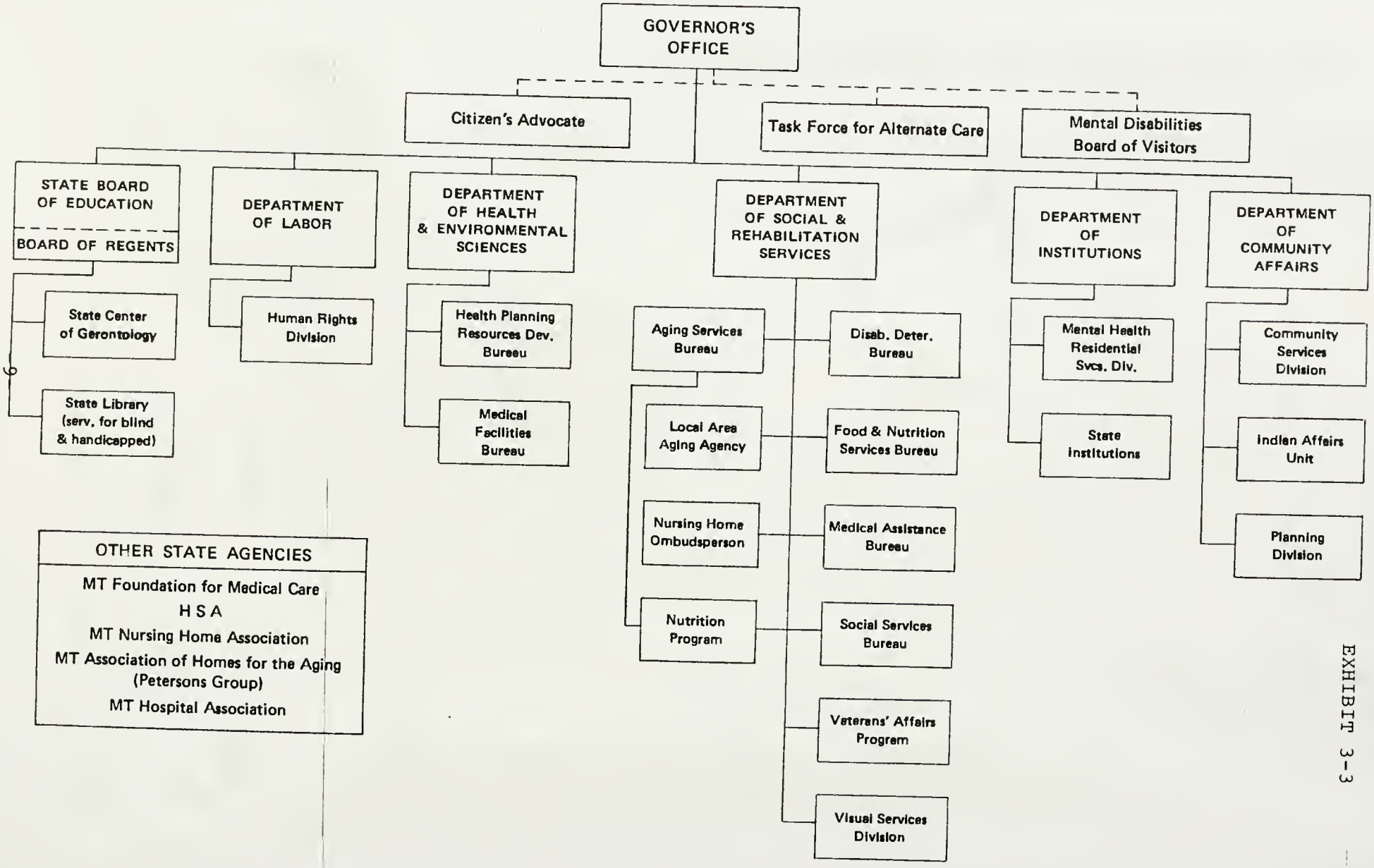
POPULATION OF MONTANA - 1970

CITIES & TOWN* DISPERSED

*Includes incorporated places and those unincorporated places having populations of 100 or more

EXHIBIT 3-2

STATE ORGANIZATIONAL STRUCTURE
AGENCIES (DEPARTMENTS) FOR LONG-TERM CARE



OTHER STATE AGENCIES

MT Foundation for Medical Care
H S A
MT Nursing Home Association
MT Association of Homes for the Aging (Petersons Group)
MT Hospital Association

EXHIBIT 3-3

Three population groups aged 65 and over were sampled, namely Medicaid eligibles in nursing homes, Medicaid eligibles not in nursing homes, and non-Medicaid elderly not in nursing homes. A total sample of 1,500 was achieved (300 in each group). Scores of less than 20 indicate institutionalization is appropriate. Scores ranging from 20 to 39 predict the utilization of an alternative to nursing home care, while scores of 40 or above indicate independent functional ability.

Exhibits 3-4 and 3-5 identify the target population and evidence their need for long-term care services in institutional settings or alternatives.

For purposes of the Long-Term Care Channeling Project, we are primarily interested in the elderly Medicaid and non-Medicaid population (65 or over) with GFRS scores between 20-39, residing at home. Rural and urban Medicaid residents in this category translates to 437 persons. Non-Medicaid at home in both rural and urban is projected at 10,421 persons.

3.4 A SUMMARY OF SERVICES CURRENTLY AVAILABLE STATEWIDE

The state is comprised of 56 counties, only three (3) of which have a population in excess of 50,000 people. As would be expected, services available vary greatly throughout the State. The relatively service-rich areas in and around the principal cities contrast with the service-poor isolated rural communities.

Certain services are generally available on a statewide basis; however, the most rural areas do not have ready access to needed services. Medical services include 1,113 physicians, 63 hospitals, and 99 nursing homes. There is an array of social services that are available generally through county and district welfare offices.

Many services essential to a wide range of long-term care alternatives are available only in selective areas or limited quantity.

Refer to Appendix B for a complete annotation of Montana services.

3.5 A SUMMARY OF OBLIGATED AND POTENTIAL FISCAL RESOURCES FOR LONG-TERM SERVICES FROM FEDERAL, STATE AND OTHER PUBLIC AND PRIVATE SOURCES

For fiscal year 1979 (ending in June), there was a total of $1,975,163 expended for Title XX programs, $53,886,575 for Title XIX programs, and $3,391,052

Exhibit 3-4

STATE OF MONTANA GFRS SCORES

RURAL (n = 828)

STATUS	GFRS Less Than 20	20-39	40 and above
Not Medicaid	3%	14%	83%
Medicaid at Home	7%	13%	80%
Medicaid in Nursing Home	78%	19%	3%

URBAN (n = 672)

STATUS	GFRS Less Than 20	20-39	40 and above
Not Medicaid	5%	14%	81%
Medicaid at Home	2%	17%	81%
Medicaid in Nursing Home	86%	12%	2%

Exhibit 3-5

PERCENTAGE OF GFRS SCORES BY AGE GROUPS, STATE OF MONTANA

Sample size, n = 1484

Age Group	GFRS Less Than 20	20-39	40 and above
65-74	15.4%	15.7%	68.9%
75-84	26.0%	13.1%	61.0%
85-95	48.3%	17.2%	34.5%
95-105	73.1%	19.2%	7.7%

for Title III programs. Other program expenditures of interest related to long-term care total $26,870,355. Refer to Appendix C for a more detailed description of expenditures in these areas.

3.6 An Analysis of Obstacles to the Development of Channeling Demonstration Projects - Montana has gained valuable experience in recognizing obstacles to channeling demonstration projects in implementing a pre-admission screening, discharge and alternate care program.

The lack of community resources, especially in rural areas, and the lack of funding to develop and expand services has proven to be a major obstacle in such a program. Medical social workers spend a major part of their time in this effort. Progress is slow and frustrating. Funding for adult foster homes, personal care homes and other types of supervised living arrangements is inadequate to attract providers or developers.

Resistance from nursing home administrators, physicians, hospital social workers, and other service providers can seriously hamper the effectiveness of a channeling program. It is of the utmost importance to explain the program's goals and involve such groups in the program to the extent possible.
Private pay nursing home admissions affect the project's ability to reduce avoidable nursing home admissions. Many private pay would welcome channeling services, however, if an outreach program was conducted to inform the public about the project.

Varying eligibility criteria for different programs often make coordination of services difficult. Cost sharing arrangements, reimbursement methods and reporting requirements add to the problem.

Another problem, which may become a barrier to channeling, relates to the design and research components of the project. A basic assumption made is that some, if not most, of the clients screened would have entered nursing homes if alternatives were not arranged. Lack of a data base at the time a program is implemented, results in an inability to objectively measure the characteristics of the target population.

3.7 An Analysis of Potential Facilitating Factors in the Development of Channeling Projects - Perhaps the single most important factor in facilitating the development of a channeling project is:

The establishment of a single local agency to identify, screen, assess, plan, and coordinate services for applicants in need of long-term care.

A comprehensive review of the literature indicates that these project elements are critical in preventing inappropriate nursing home placements. After the screening procedure identifies those applicants for channeling services, a comprehensive needs assessment must be made to determine the type of services needed. Coordinating the package of services for individual clients, and seeing that the client receives the services are basic to the success of a channeling project.

Other facilitating factors include: a single funding source which allows the channeling agency the flexibility to reimburse for needed 'gap' services; controls over costs and utilization; and control over non-medical nursing home admissions.

The availability of a variety of service options at the local level enhances the developemnt of channeling. Existing services provide the base to expand and develop the service area.

Cooperation and linkages between the various provider groups and agencies is also a necessary component in facilitation of channeling projects. These linkages alleviate the hassles of 'turf' protection. The involvement of all long-term care providers including nursing home administrators, physicians, and hospital discharge planners is a part of this cooperative effort.

Careful project design and implementation of the research is essential to the successful demonstration project. Conclusive evidence regarding the effectiveness of the services in preventing inappropriate long-term care placement resolves the question of whether the services provided were actually 'alternatives' or 'add-ons'.

Finally, a carefully designed evaluation component carried on throughout the development and implementation of the project is necessary for guidance in all aspects of a successful project.

3.8 Analysis of State Readiness for Project Implementation - The State of Montana has long been committed to serving its elderly and handicapped residents. Through the years, various approaches have been initiated to provide needed services to this target population. The following narrative briefly describes

and illustrates the State's leadership and efforts in meeting the needs of its elderly citizens.

Montana's Rural Social Service Delivery System, an 1115 Project, # 11-P-57183, began in July, 1971, and lasted through June, 1974. This project established direct social service delivery, without regard to income, to the rural population of a five-county area in northeastern Montana. A highlight of this project relating to channeling objectives demonstrated that the use of homemakers prevented the institutionalization of 217 adults in a two-year period in sparsely populated rural areas of Montana.

Another 1115 Project, # 11-P-57110/8-01, entitled Helena Comprehealth was initiated on July 1, 1970. The major emphasis of this project was to demonstrate that a prepaid system of medical insurance coverage utilizing a private insurance carrier is a feasible and practical way to assure that a medically indigent target group would receive appropriate health care. This project utilized outreach and social service delivery to increase the effectiveness of the program. The project ran through September 30, 1973. A closely related 1115 Project, # 11-P-57109/8-1, the Delta Dental Plan, began on October 1, 1972; provided dental services to medically indigent population in Butte, Montana.

The Montana State Department of Social and Rehabilitation Services currently is the recipient of a Primary Care Research and Development (PCR&D) grant. This was formerly know as Health Underserved Rural Areas (HURA). Under the terms of this grant, SRS is to develop an organizational model that could be applied to other projects, service provision arrangements, and programs.

While the potential clients and specific services are quite different, both the PCR&D project and the National Long-term Care Channeling Project are dealing with the identical problems of a service delivery system, a variety of agencies who have a mandate to provide services, and local-state-federal jurisdictional problems. Both hard data from formalized research designs and soft information from demonstration narratives can be provided. There is the flexibility to pilot alternative service delivery models and there is the mandate to correct problems and to institute a more effective delivery system.

Montana initiated a pre-admission screening discharge and alternate care program in June, 1978. This pro-

gram is a cooperative effort between the Montana Foundation for Medical Care (Montana's PSRO), Social Services Bureau, and the Medical Assistance Bureau of Montana Social and Rehabilitation Services. The program was funded by an interim legislative committee in 1978. The 1979 legislative session reduced the number of staff positions due to budget constraints. As a consequence, the program is limited in scope in terms of geographic area and target population. The assessment form utilized in this program and a detailed description is attached as Appendix I.

The formation of an inter-agency Task Force, May 17, 1979, for the purpose of recommending long-term care budgets and legislative considerations for the 1982-83 biennium, resulted in a concentrated emphasis on this critical area of concern. This Task Force and its alternative study was discussed in Section 3.3.

Montana has made many major commitments to the channeling objectives. Currently, the foremost of these are the establishment of an inter-agency Task Force and the acquisition of a reliable data base upon which long-term care planning decisions can be more accurately made.

The National Long-Term Care Channeling Project is a natural transitional step (at a most propitious time) in Montana's continuing efforts in serving the needs of the elderly in Montana in an appropriate framework.

4. BACKGROUND INFORMATION ON LOCAL COMMUNITY DEMONSTRATION

4.1 Site Selection - Since the seven area agencies on aging in the State of Montana are charged with the administration of programs and services for the elderly at the local level, their cooperation and knowledge was essential in local site selection. A meeting of all directors of the Area Agencies was held in Helena, Montana on May 9, 1980. A presentation was made at that time explaining the channeling project and providing information and material. (See Appendix G). These Area Agency Directors were requested to contact agencies in their area whom they thought would be interested in submitting proposals for the channeling demonstration project and invited to submit proposals of their own. They also agreed to provide information to any agency referred to them through other sources.

As a result of this meeting, three (3) proposals were submitted for consideration by the date set for their receipt, May 26, 1980. The volcanic ash fall-out from Mt. St. Helen's eruption caused mail service delay and resulted in at least one interested agency's inability to respond.

A selection committee composed of representatives from Aging Services, Social Services and Medical Assistance reviewed the proposals and selected two of the three proposals for site demonstration. (See Appendix G for evaluation criteria.)

Proposals selected came from:

Missoula County Council on Aging - Missoula, Montana (site includes the counties of Missoula, Ravalli and Mineral). Proposal is presented in Appendix D.

Area V Area Aging Agency - Anaconda, Montana (site includes the counties of Powell, Madison, Beaverhead, Granite, Silver Bow and Deer Lodge) (See Attachment). Proposal is presented in Appendix E.

A map outlining the catchment areas is presneted in Exhibit 4-1.

The State of Montana is confident that a successful channeling demonstration project can be accomplished in these areas. Evidence is presented in the following discussion of each individual site, including the advantages and disadvantages of each site.

MONTANA

LOCAL CHANNELING SITES

Missoula Site –

Anaconda Site –

EXHIBIT 4-1

The intended relationships between state level activities and the proposed demonstration areas, including a description of the working relationships and accountability mechanisms between state-level project activities and local demonstration activities and how the proposed structure will assure administrative and programmatic accountability and effectiveness in accomplishing project objectives at the state and local level, are described in Section 6.3.

4.2 Description of Missoula Site - This site comprises three counties in the Western sector of Montana. The counties represented are Missoula (the city of Missoula is the 3rd largest city in Montana); Mineral and Ravalli. Exhibit 4-2 presents demographic statistics of the three counties.

The catchment area has an estimated 1980 population of 94,348. The community of Missoula is the largest urban center in the area with 34% of the area's population within its boundaries. Another 41% of the area's population are outside the Missoula city limits, but within easy driving distance. The remaining 25% of the area's population are located in five communities of less than 3,500 people each and the rest are in unincorporated settings. The region lies in a 'five valley' area at the foot of the rugged Rocky Mountain range. Timber and the manufacturing of timber products are important industries in this region of high mountains and deep valleys.

4.2.1 Target Population - Exhibit 4-3 presents the estimates of alternative care candidates in the area. Both a high and low estimate are presented. The high estimate calculation for Medicaid recipients in nursing homes who would be eligible for an alternative is performed by multiplying the number of Medicaid recipients in nursing homes in the region by the percentage of surveyed Medicaid recipients in nursing homes in the region who scored 20 and above on the GFRS, (predictive of the utilization of an alternative to nursing home care). The result is 38 nursing home residents who could be displaced from nursing homes if suitable alternatives are available. The low estimate for Medicaid residents in nursing homes is 0. This estimate is based on JRB's discussion with ACCESS personnel in Rochester, New York who indicated that almost no alternative to long-term care program clients come to the program from nursing homes. The second calculation of estimating channeling candidates is performed for the Medicaid at home recipients. The number of Medicaid at home residents in the region (485) is multiplied by the percentage of surveyed respondents in this category in the rural

Exhibit 4-2

Counties	Population*	Square Miles	Population Density	Population Over 65
Missoula	71,385	2,612	27.32	5,853
Mineral	3,192	1,222	2.61	286
Ravalli	19,771	2,382	8.30	2,985
TOTALS	94,348	6,216		8,838

Exhibit 4-3

STATUS	HIGH ESTIMATE	LOW ESTIMATE
Medicaid in Nursing homes % GFRS scores 20 +	271 x .14 = 38	0
Medicaid at Home % GFRS Less than 40	393 x .11 = 43	393 ½% GFRS 20-39 = 17
Non-Medicaid % GFRS Less than 40	8,175 x .07 = 572	8,175 ½% GFRS 20-39 = 286
TOTAL ESTIMATE	653	303

* Population arrived at by averaging 1975 and 1985 population projections from Montana Population Projection 1975-2000, Montana Department of Community Affairs, August 1977.

counties of the region who have GFRS scores of less than 40. The high estimate yields 11% in this category for a total number of 43. The low estimate takes the same population base of 393 and multiplies it by one-half of the percentage of the sample in this status category who have GFRS scores ranging from 20 to 39. This yields 17 candidates. This more conservative approach is taken by addressing only those who have scores which indicate the use of the alternative and assumes that only half of them would participate in an alternative program. The other half might go into nursing homes or might continue to live in the present arrangement with or without support from family and friends.

The non-Medicaid population for the region is calculated by averaging the 65 and over population estimates for the three counties in the region and then subtracting the Medicaid recipients at home and in nursing homes from the same geographic area. This results in 8,175 as the population base for this category. No adjustment was made for non-Medicaid recipients in nursing homes, but it is believed that this is a relatively small proportion of all non-Medicaid recipients living in the geographic area. The high estimate for this region is based on multiplying this population estimate by the percentage of the respondents in this category who have GFRS scores less than 40. The low estimate is calculated by multiplying this population by one-half the percentage of the respondents in this category who have GFRS scores ranging from 20 to 39. The resulting high and low estimates for this geographic area are 653 and 303 respectively.

4.2.2 Summary of Services - Long-term care services currently available in this demonstration area include: congregate meals, home delivered meals, transportation, outreach, telephone reassurances, personal care, home nursing, information and referral, counseling, home chore, social services, therapies (P.T., Q.T., Speech), audiology, weatherization, fuel assistance, advocacy, and legal services. A complete listing of levels of service, providers, and number of clients served is included in Appendix D.

4.2.3 Roles and Responsibilities of Agencies Providing or Supporting Such Services, Degree, Types, and Levels of Coordination Among Agencies - The Missoula County Council on Aging is a non-profit corporation, was established to plan, coordinate, administer and develop programs for the elderly in this area. The Council represents the following agencies and interests:

Nursing Homes
Social and Rehabilitation Services
YWCA
Health Department
Nutrition
R.S.V.P.
Senior Center
Indian Center
Housing Authority
University of Montana
Special Needs Transportation
Information/Referral
County Welfare Department
Community Action Agency
Alcohol Programs
Mental Health
Western Montana Radio Reading Service
Area Agency on Aging
City of Missoula
County of Missoula
League of Women Voters

An indepth discussion of the roles and responsibilities of the agencies providing long-term care in Missoula is appended. (See Appendix D).

4.2.4 Problems and Gaps in the Current System - The Missoula County Council on Aging is presently in the process of conducting a need survey among providers of long-term care services. Preliminary results indicate that the present service capability is responding to approximately 15-20 percent of the existing level of need. Services needed expanding or developing include home health care, home chores, home delivered meals, transportation, housing, rehabilitation, friendly visiting, shopping assistance, and escort service.

4.2.5 Advantages and Disadvantages of Missoula Site - A strong network of inter-agency linkages is immediately apparent in reviewing this site proposal. Commitment to the channeling objectives is documented in the existing service delivery system. The high estimate of 653 potential channeling clients and a low estimate of 303 assures that the project will meet the 300 - 800 channeling client requirement. The major population areas in this demonstration site are linked by major highways, making travel easy.

A limited pre-admission, discharge and alternate care program is presently being conducted in this area. It involves a medical social worker employed by Montana Social and Rehabilitation Services and an R.N. employed by the Montana PSRO. Limited assess-

ments, due to lack of staff, post-admission assessments, and the resistance to the program from a major hospital have been problems in this area.

The four (4) nursing homes in Missoula also suffer from bed vacancies. This fact may result in nursing home providers resistance to any new program which may affect their occupancy rate.

4.2.6 Description of the Proposed Channeling Agency - Missoula Site - Presently, the Missoula County Council on Aging, a non-profit organization, is an administering, planning, and coordinating agency for all aging funds allocated to the County. This involves the coordination of all grant applications through the utilization of the Council as the submitting grantee agency. The Missoula County Commissioners are currently working with the Council and all aging service providers to use the Council as the 'Channeling' agency to administer all funds appropriated for aging services by the County. This process should be in place by September of 1980. Once the total process is complete, in terms of consolidating all grant functions, the Council will advertise RFP: for specific services which were identified through the planning process. After the contracts have been awarded to the various social service providers, the Council monitors and evaluates the delivery of services under each contract. This function is performed by the Council Aging Coordinator, and the members of the Evaluation Committee.

The present management of the services in Missoula utilizes the County Council in terms of a focus to manage the resources to contract for various needed services. If this project would be developed within the Counties of Missoula, Ravalli, and Mineral, the County Council would subcontract the City/County Health Department as the local agency to coordinate and implement the project. See Appendix D (organizational chart).

4.3 Description of Anaconda Site - This catchment area includes a bloc of six (6) counties in the southwest corner of the State with a 1980 population of 84,451. Counties included are: Powell, Madison, Beaverhead, Granite, Silver Bow, and Deer Lodge. The community of Butte, in Silver Bow County, ranks 5th in State population. Known as the 'Richest Hill on Earth' it is the mining center of the State, rich in copper, zinc, gold, and silver. Smelting of the ore is performed in the nearby community of Anaconda. These two communities have 41% of the catchment area's population within their urban boundaries. An addi-

tional 29% of the area's population are outside the Anaconda and Butte city limits, but within easy driving distance. The remaining 30% of the area's population are located in two communities of approximately 5,000 people each, three communities of less than 2,500 population, and the rest are in unincorporated settings. Demographic statistics are presented in Exhibit 4-4.

4.3.1 Target Population - Exhibit 4-5 presents both the high and low estimates of alternative care channeling candidates in this area. The calculations were made in the same manner as explained in the narrative for the Missoula Site (4.2.1). The high estimate is 1,019 clients while the low estimate indicates 488 clients predicted to utilize channeling services.

4.3.2 Summary of Existing Services - The following is a Summary description of services available to all elderly regardless of income:

1. Home Health Care - Silver Bow, Madison, City of Dillon, Powell, and Deer Lodge Counties.

2. Home-bound Elderly and Handicapped Homemaker-Chore Services: Six County Planning and Service Area.

3. In-home supportive services available to home-bound elderly and handicapped include: Homemaker Chore service, shopping assistance, minor home repair, home delivered meals, and in-home meal preparation information, referral, outreach, friendly visiting, recreational supplies, weatherization and Social Welfare counseling: Silver Bow, Madison, City of Dillon, Powell, Granite, and Deer Lodge Counties.

4. Congregate meal sites strategically located throughout the Six County Planning and Service Area accessible to 'pockets' of elderly.

5. Transportation and Escort available to some elderly throughout the Six County PSA (limited).

4.3.3 Roles and Responsibilities of Agencies Providing Supporting Such Services; Degree; Types; and Levels of Coordination Among Agencies - The Area V Agency on Aging contracts with various agencies to provide supporting services. These include:

1. Contract with Area V Home Health Agency, City/County Home Health Agency, Butte, to provide skilled nursing, Home Health Aide, Homemaker and other rehabilitative and maintenance services.

Exhibit 4-4

ANACONDA SITE

COUNTY	POP*	SQUARE MILES	POP DENSITY	POP OVER 65
Powell	8,257	2,336	3.53	713
Madison	5,678	3,528	1.60	881
Beaverhead	8,697	5,551	1.56	917
Granite	2,750	1,733	1.58	364
Silver Bow	43,728	715	61.50	5,049
Deer Lodge	15,341	740	20.73	2,059
Totals	84,451	14,603		9,983

Exhibit 4-5

Status	High Est.	Low Est.
Medicaid in nursing homes 20+	378 x .10 = 38	0 % GFRS
Mediaid at home less than 40 20-39,	302 x .17 = 51	302 x % GFRS ½% GFRS 7.5 = 23
Non-Medicaid % GFRS less than 40	9305 x .10 = 930	9305 x ½% of GFRS 20-39,5 = 465
Totals	1019	488

* Population arrived at by averaging 1975 and 1985 population projections from Montana Population Projections 1975-2000 Montana Dept. Community Affairs, Aug. 1977.

These Home Health Agencies receive reimbursement from Medicare, Medicaid, Older Americans Act monies, State General Fund monies, and local tax dollars.

2. Access services include transportation and escort for those isolated medically handicapped persons (Direct service through contractural agreements and volunteers with local agency projects).

3. Green Thumb (contract) to provide friendly visiting, shopping assistance, personal grooming, and recreation.

4. Employment Security (contract). Community service aids to provide staff for Home-Chore and Senior Center maintenance.

5. Butte/Silver Bow Anti-Poverty Council contracts for nutrition services for congregate and home delivered meals. Information and referral for winterization and energy assistance.

6. Butte/Silver Bow County Health Department (formal and informal support services).

Formal and informal agreements with the Veterans' Administration, Mental Health, Alcohol and Drug Program, State and local medical providers, welfare, housing, law enforcement, Vocational Rehabilitation, Social Security, Easter Seal, civic and volunteer organizations are maintained. This area has also worked with the Department of Housing and Urban Development and Economic Development Administration in funding a building complex to house the agency and all service delivery components for the Six County Planning and Service Area.

4.3.4 Problems and Gaps in the Current System - The Area V Area Agency Director has identified the following services, which need to be expanded or developed.

Expand:

- In-home supportive services
  - home health services
  - homemaker chore services
  - home delivered meals
- Congregate meal sites
- Special transportation

Development of:

- Day care
- Respite care

The Montana pre-admission screening program has identified personal care and companion services as needed on a state-wide basis. See Appendix H.

4.3.5 Advantages and Disadvantages of Anaconda Site - This site has strong leadership at the local level -- "things get done". Linkages with service providers, both direct and indirect, are in place with documented inter-agency cooperation. The population range of potential channeling clients from a low of 488 to a high of 1,019 coincides ideally with the required base of 300-800 clients. The area's mix of urban and rural population presents an opportunity to demonstrate delivery of service in different ways and will challenge the creativity of the project staff. 70% of the target population live within the Butte-Anaconda area.

The larger geographic area will present problems in terms of travel to the rural, isolated areas; especially Beaverhead and Madison Counties, where 'pockets' of elderly are scattered throughout. Severe winters in this sector of Montana will further complicate this problem.

This area is also experiencing a low occupancy nursing home bed rate due to a population decline and is considered to be an economically depressed area.

4.3.6 Description of Proposed Channeling Agency - Anaconda - Area V Agency on Aging is a non-profit organization charged with the continuing process of planning services for the elderly in a six-county area. This agency coordinates and contracts for the actual delivery of needed services at the local level. The first goal of this agency is to provide services which prevent inappropriate institutionalization. An organizational chart is appended as part of Appendix E.

5. TECHNICAL APPROACH

This section contains specific plans for meeting project objectives and performing each task specified in the RFP statement of work. Timetables for undertaking these plans and task performance are included in the Management Plan, Section 6.1. The technical approach for an alternative proposal is presented in Section 5.10.

5.1 Phase I, Task 1: State Long-Term Care Planning - The State has been in the process of developing a long-term care plan for one year. This is the objective of the multi-agency task force that was formed in May, 1979, to develop the alternative study described in Section 3.3.

It has been the State's intention to follow-up the study with a long-term care plan, which would be prepared by an expanded LTC task force. The opportunity to submit this proposal for a channeling demonstration has almost coincided with the State's schedule to layout a framework for moving forward with the preparation of the LTC Plan. The State's own agenda has been to put a plan together that would initially be of benefit during the upcoming legislative session, which convenes on January 2, 1981, for a ninety-day session. (Montana's legislature convenes biennially.)

Montana will still do that, but in the context of this proposal, that effort will be an interim LTC Plan focusing on legislative proposals and State budget considerations. Should Montana be selected as a contractor, the opportunity to further develop this plan is moved up from what the State would otherwise be able to do.

The Governor is establishing a Long-Term Care Planning Group that draws membership from several State agencies and other agencies with interests and responsibilities in the area of long-term care. This group is being formed from the nucleus that currently exists as the task force to study and make recommendations to the State Health Coordinating Council on alternatives for long-term care. This task force is made up of representatives from the following Montana agencies:

- Department of Health and Environmental Sciences (the designated State Health Planning and Development Agency)
- Department of Social and Rehabilitation Services

- Department of Institutions (responsible for Comprehensive Mental Health Service and Community Mental Health Centers)

- Montana Health Systems Agency, Inc. (Montana is a single HSA state)

- The Governor's Office.

The expanded group will be chaired by Mike Miles, Special Assistance in the Governor's Office. In addition to the prior task force membershipm the LTC Planning Group will be expanded to include SRS's Project Management Team and a representative from the Governor's Office of Budget and Program Planning. The Administrator of the Federal Government's Health Care Financing Administration will appoint the REgion VIII Director of HCFA to represent the Medicare program on the Group.

The ten member LTC Planning Group will be assisted in its efforts by an ad hoc resource group. The resource group will be available for consultation and input as long-term care issues raised by the channeling demonstration may require. Specific individuals in each agency or organization will be identified as the key person for functioning as a resource to the Planning Group. Background information about the channeling demonstration and other relevant information will be distributed to Resource Group members so that they may be better able to respond to information needs as they come up. An initial list of proposed Resource Group agencies and organizations are listed below. Others not listed may be added later as they become identified as resources.

- Montana State Bureau of Housing and Community Facilities

- Montana State Division of Developmental Disabilities

- Montana State Division of Vocational Rehabilitation

- Montana Legal Services Association

- Montana Senior Citizens Association, Inc.

- Montana Foundation for Medical Care

ıtana Hospital Association

ntana Nursing Home Association

›ntana Home Health Agencies Association

ontana Association of Housing for the ‹gency

al level, the lead agency for each site has ng advisory group that will serve as a ınd coordination base for the demonstration.

Task 2: Site Planning - Site planning is to ›lished within two months of contract award, ıg with a report that details all the ents needed to administer the channeling at the Anaconda site and the Missoula site. ıs to be able to respond to this quick startup ınging for the hiring of SRS administrative and the SRS technical consultant before the t is awarded, but contingent upon Montana selected as a contractor. Section 6.1.1 out- a realistic schedule that indicates that SRS ›e capable of responding to this requirement. ıl also insure responsiveness by reviewing the requirements of this task with each lead agency and asking them to begin putting material together in anticipation of a possible contract award; both agencies have already indicated a willingness to do so.

SRS has also designated an interim project manager to be responsible for precontract activities and to aid in the transition as the permanent project manager is brought on board. The permanent project manager and the interim manager and the SRS technical consultant will be ready to work at the local sites in cooperation with the government project officer and designated staff of the National Channeling Demonstration Program during this initial period to prepare the necessary material.

5.3 Phase I, Task 3: Site Development - Using the subcontract form developed as a part of the report called for by Task 2, SRS will subcontract with the government-selected local lead agency for conduct of the local community channeling project. Although conditions and restrictions essential for SRS responsibilities as a government contractor will be incorporated in the subcontracts, SRS intends for local administrative and management practices to prevail in such matters as hiring project personnel, the identification of appropriate resources and services

needed to achieve project objectives, develop formal and informal agreements among resources and services, and maintaining informal consent procedures.

The development of case finding/screening/referral mechanisms and procedures will be the responsibility of the local lead agency, although to the extent that SRS may facilitate this, that will be done. However, the design of the prescreening instrument and the procedures for its use will be handled by SRS through its technical consultant. Conditions in the subcontract will be stated to require that the characteristics of the caseload reflect the following criteria:

- At least 75% of the client caseload will be selected from among persons 65 years and older who, because of chronic physical, mental or emotional conditions, are unable to care for themselves without the persistent help of others over an extended period of time.

- Channeling clients are typically expected to have multiple problems or needs which require several different services.

- Individuals being discharged from acute care facilities, nursing homes or referred by the PSRO, and individuals applying for Medicaid nursing home reimbursement should be given preference in selecting channeling participants.

Income will not be used as a factor in identifying participants for assessment and case management services, except as that may be required under Task 5 for gap-filling services.

Although both proposed local sites have established advisory groups in the community, the subcontract will specify that such a group or a new group, if necessary, be utilized to help in maintaining and building relationships between the project and other programs, providers and consumers.

The subcontract will specify that the local lead agency will pre-test, in conjunction with the national evaluation contractor, all standardized forms and procedures associated with the client assessment instrument and the client tracking and cost reporting system. SRS will participate in this activity, through its technical consultant, to assure proper coordination with the prescreening instrument and other SRS data collection requirements.

During the site development stage and into the implementation stage, SRS is prepared to have both the SRS Project Manager and the Site Project Manager attend four meetings in Washington, D.C., which the government project officer will arrange. In the case of the meeting to be held no later than one month after final local project selection, the local site person attending may be an official of the local lead agency rather than the project manager.

Throughout the year of site development, the SRS Project Manager will monitor site activities according to subcontract specifications and conclude an evaluation of site readiness for channeling implementation which shall be used to prepare an interim report for government project officer review and approval.

Included in this report will be SRS's own readiness for channeling implementation in terms of established procedures for internal research and evaluation to assist in the improvement of project performance, and the system by which data shall be collected and reported. An information system in support of data requirements is outlined in Section 5.3.1.

5.3.1 Data and Information Systems - For the project as a whole, the design, development, and implementation of a data/evaluation system for the project is an important function. Based on the experiences of the SRS-PCR&D project (see Section 3.8), both positive and negative, a plan of operation has been developed that will allow for the expeditious implementation of a data/evaluation system for the channeling project.

1: Preliminary development of an evaluation design. While much of this design will subsequently be revised and modified, a preliminary design is required. The design is a base against which to compare and contrast during the first several months of operation as to the types of information actually being obtained as opposed to the types of information that the project anticipated being obtained. This preliminary design also indicates the wide range of specific data to be collected from the initial start, regardless of whether it ultimately is utilized. Portions of this preliminary design will be eliminated, portions will be modified, and sections will be discovered during operations that need to be included. These management administrative decisions cannot be made unless there is a base from which to develop.

The PCR&D program expended approximately 110 hours in the development of this preliminary design, preliminary listing of data elements, and preliminary listing of research hypotheses and demonstration topics.

2: Mechanical collection, correlation, and analyses of data. For the first several months of operation, the SRS-PCR&D service site has mechanically collected data and done preliminary correlations and analyses. One of the negative experiences was that provision was not made for either staff allocation or budget allocation for technical assistance in performing this function. As a result, we do not know the time required for the performance of these activities. The channeling project will have this capability unlike the PCR&D project.

3: Revision of the evaluation design. Based on the experiences at the project site over the first few months of operation, a formal revision of the evaluation design needs to be accomplished. Sections of the design that are not consistent with reality need to be eliminated. Some sections can be approved in their entirety and included within the final evaluation design. Some will need revisions. And, there will be discovered areas to be added that had not been previously considered.

The revision is to be accomplished with the cooperation of a variety of agencies. Federal reporting requirements, central and regional office areas of interest, state reporting requirements, state agencies areas of interest, and the potential utilization of the data and information by the interagency task force. All the groups, with the varying requirements and areas of interest, need to be consulted during the process of developing a final evaluation design.

4: Development of a systems design to implement the evaluation design. The first task to perform is to determine if there is an existing documented software package that could be utilized with relatively minor modifications. A considerable savings could be accomplished if such a documented program were available. In the case of the PCR&D, this was found not to exist as far as could be determined.

The systems design is to include all three functions of the operation: fiscal, program operations and management, and program evaluation. Developing the program and the operation is estimated at 500 hours.

5: Obtaining hardware and other equipment. In conjunction with the size and complexity of the evaluation design, the systems design, program operational and management requirements, hardware needs to be acquired. Capacity, present and anticipated, cost, cost utilization, need to be considered in preparing written documentation as to which alternatives present the greatest advantages at the least cost.

For the PCR&D project it is estimated that this task will require 128 hours for a total cost of $4,150. This excludes the actual cost of obtaining equipment. Two alternative pieces of equipment are being considered. One is equipment on the market by Radio Shack, the other with a greater capacity and speed, is Data General.

6: Development of materials and procedures for the operation of the system. Developing the procedures manual, training staff, designing forms, monitoring the collection of data, de-bugging the program, and assuring the routine maintenance of the software are part of this function. In addition, because of at least a few months of operational status, during which time rather voluminous data has been collected, the project must go back and enter all data collected to date.

It is estimated that the successful performance of this task will require slightly over one thousand hours.

7: Completion of periodic analyses to be completed. Federal and state reporting, as well as specific analyses required by the evaluation design need to be completed on a periodic basis. The PCR&D project is requiring this to be done quarterly. For the quarterly reports, this requires an expenditure of 142 hours. This figure is one year's total. Depending upon the complexity of the final evaluation design, the types and amounts of analyses to be developed, this is probably a somewhat low figure for the channeling project; however, it is expected that the national contractor will provide the additional time and resources required for evaluation purposes.

5.4 Phase I, Task 4: Channeling Implementation - SRS will implement the basic channeling functions through its channeling subcontractor once the government project officer has approved the interim report specified in Section 5.3

Exhibit 5-1 indicates the flow of channeling services proposed for the Montana project. It is to be expected that local variations would be built in as more detailed specifications are developed as a part of the site development process described in Section 5.3.

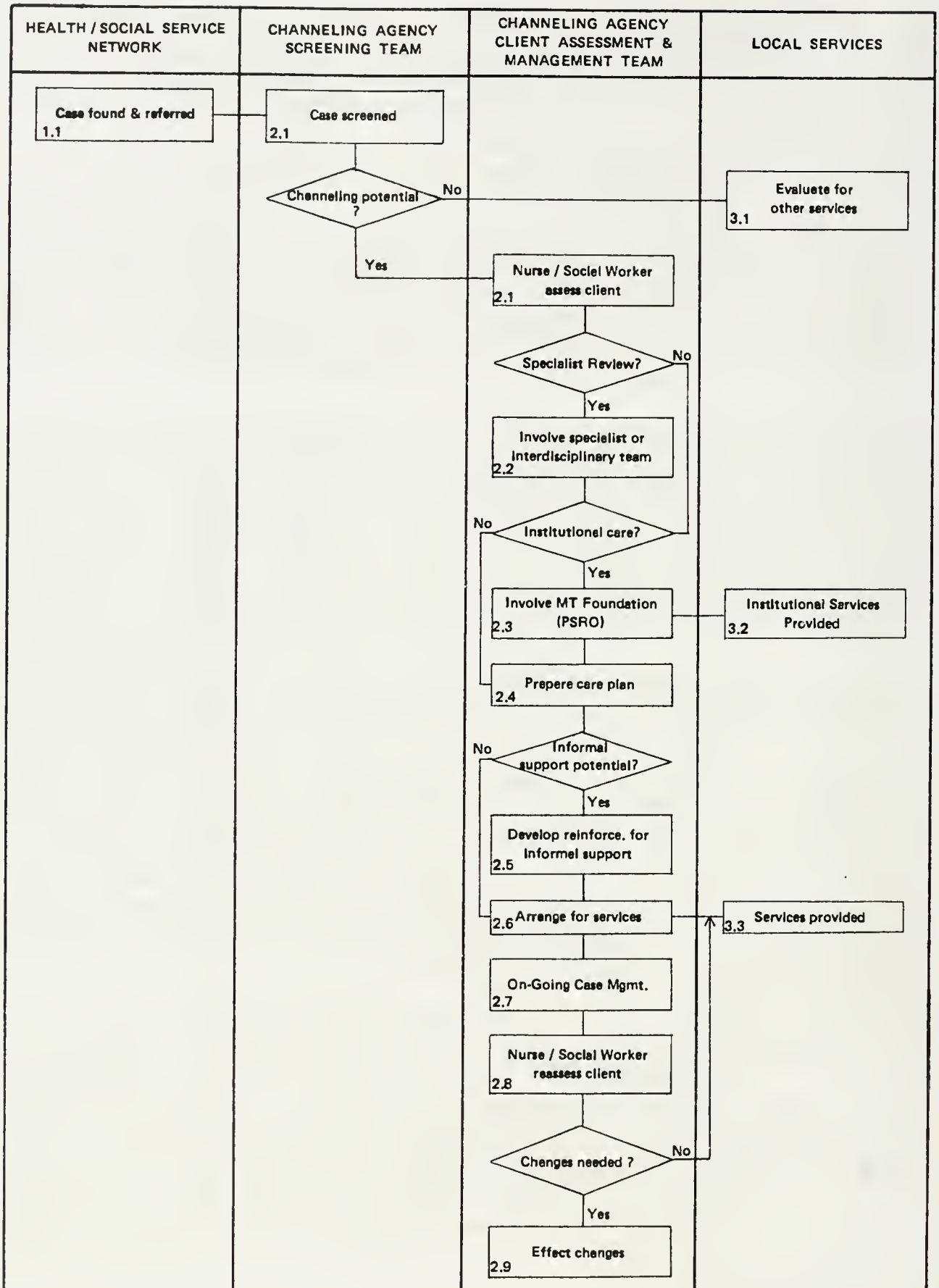
5.4.1 Screening - Cases for screening (1.1) will be found through the health/social services network already established at the site. The community education efforts conducted as a part of site development will focus on encouraging referrals. A screening process will be established within the lead agency to receive screening referrals and conduct the screenings. This process will be separated administratively from the other lead agency channeling functions of client assessment and management.

SRS proposes to use the Geriatric Functional Rating Scale developed by Dr. Grauer as the basis for the screening instrument. The GFRS became the selected instrument to be used in Montana's study of long-term care alternatives. This instrument was chosen after careful consideration. Exhibit 5-2 contains summary information about seven existing survey questionnaires which are currently being utilized to assess health care needs of the elderly, primarily in evaluating the feasibility of alternatives to nursing home care. The majority of these questionnaire require qualified medical and/or social work personnel for partial or total administration. Two of the instruments, the Geriatric Functional Rating Scale and the Older Americans Resources and Services Program (OARS Program) survey instruments, have been widely utilized, can be administered by lay personnel and can be administered in approximately 30 minutes or less. The utilization of both instruments is much greater than the experience shown in Exhibit 5-2, since available reference material is somewhat dated and both instruments are being widely used. The use of the GFRS in Montana alone involved a survey of 1,500 elderly persons.

The Geriatric Functional Rating Scale has been validated by Dr. Grauer and his colleagues. Exhibit 5-3 summarizes the follow-up study that was conducted on 130 subjects by reviewing their actual outcome compared with the predicted outcome 18 months after the initial rating. While the results are not 100% perfect, they are impressive. The alternative proposal presented in Section 5.10 concerns the opportunity to conduct additional validation of the GFRS for the elderly person who has not been previously identified as a possible institution bound individual.

EXHIBIT 5-1

MONTANA CHANNELING DEMONSTRATION
CHANNELING SERVICES



SUMMARY OF ASSESSMENT INSTRUMENTS

	ACCESS, NY	BOULDER CCO, CO	DENVER, DRCOG, CO	EROS – QUEBEC	GERIATRIC FUNCTIONAL RATING SCALE	UTAH	OARS – SEVERAL
1. Approximate Number of Survey Questions	36	25	90	60	30	21	101
2. No. of Survey Pages	6	10	25	16	2	8	32 - 42
3. Year of Use	1977 - 79	1977 - 79	1977	NA	NA	1977	1975 - 77
4. Population Sampled (Age)	18+	60+	60+	NA	NA	NH Patients 60+	50+
5. No. Surveyed/Assessed	1000+	136	303	NA	130+	168	1000+
6. Interview Time (minutes)	NA	NA	36 - 65	NA	NA	NA	30 - 60

A COMPARISON OF INITIAL SCORES AND OUTCOMES FROM THE GERIATRIC FUNCTIONAL RATING SCALE

INITIAL SCORES – PREDICTION	OUTCOME 18 MONTHS AFTER INITIAL RATING				
	LIVING IN COMMUNITY	LIVING IN PROTECTIVE SETTING	IN INSTITUTION	DECEASED	TOTAL
0 - 19 Institution Placement	5	1	21	9	36
20 - 40 Some Supportive Care, but not Nursing Home	5	7	2	3	17
41 + At Home	69	2	4	2	77
TOTAL	79	10	27	14	130

We estimate that there may have to be one (1) person year per year for screening at either of the proposed sites in order to service the potential referrals. We estimate approximately 1,300 referrals a year, with one screener using the GFRS based instrument being able to screen that number (6 a day on the average). The number of screens per day could be brought up if the travel factor for rural areas didn't have to be considered.

If the individual is determined not to require channeling services, the screener and the local channeling agency will help the individual to locate other, more suitable services (3.1). If an individual is determined to be appropriate for channeling services, the individual will be referred for a comprehensive assessment (2.1).

5.4.2 Assessment and Case Management - A combination nurse/social worker team will conduct each assessment in the home, or in a hospital or long-term care facility, as appropriate. They will be employees of the local channeling agency hired specifically for the purposes of this project. The assessment instrument developed by the government will be used with the addition of site specific questions and procedures to satisfy local project needs as developed with SRS's technical consultant.

If as a result of the assessment the team members determine that more specialized examination is necessary, they will arrange for a specialist or interdisciplinary team as required (2.2). They will determine whether institutional care is called for. If so, the team will involve the Montana Foundation for Medical Care (PSRO) to determine institutional admission (2.3) (3.2).

Non-institution bound clients will have a care plan prepared (2.4) which will:

- identify the goals to be achieved through the proposed treatment;
- identify the scope, amount and duration of services required;
- identify the sources of the proposed services including informal and formal caregivers; and
- identify the costs of each recommended service and the propcsed source of payment.

If the plan of care indicated that there is informal support through family or friends, either existing or potential, this resource will be reinforced first before arrangements for more formal services are made (2.5). The social worker will then make arrangements for provision of formal services and will make use of all client entitlements and other program benefits for which they are eligible to finance services specified in the care plan (2.6) (3.3).

SRS will take the responsibility for negotiating with state agencies to insure that:

- To the extent permitted by law, eligibility determinations of channeling clients for service programs will be delegated to staff of the channeling project; or

- outreach workers of the respective service programs will visit the project on a regularly scheduled basis or be stationed at the site for a designed period of time.

- The project will work to secure a pool of resources from other agencies and programs under agreements that delegate control of pooled resources to project staff.

- The project will negotiate with service providers to assure that channeling clients receive needed services.

SRS will use the LTC Planning Group as a means of presenting such issues and obtaining broad based support for resolving them early on.

On-going case management (2.7) will be conducted by the social worker, who will use uniform standards and criteria for monitoring the quality, timeliness, and appropriateness of the services arranged for and/or purchased by the channeling project. The social worker's on-going contacts with clients and services will indicate whether crisis intervention is necessary. If a crisis hasn't dictated otherwise, clients will be reassessed at least every six months by the nurse/social worker team, using the government developed assessment instrument (2.8). Based on this reassessment, the care plan will be adjusted to reflect changes in client needs, and the continuing availability of particular services.

We have estimated that it will take one (1) nurse and four (4) social workers for the 300 to 500 clients expected to be in the program to carry out the pro-

posed client assessment, reassessment, case management continuum throughout a year. This is based on the assumption that a nurse and a social worker can conduct two (2) assessments or reassessments in a day. A social worker's caseload under the program's case management responsibilities should be limited to 75 clients at a time. However, with the expected turn over factor, up to 500 clients should be accomodated by the staff in a year's time.

5.4.3 Services Audit and Program Review - SRS will contract the audit and program review activity (as scheduled in Section 6.1), to the Montana Foundation for Medical Care, Inc. This organization is the Professional Standards Review Organization for medical services provided under the Medicaid and Medicare programs. (This is a single PSRO state.) The Foundation also works with the SRS Medicaid program in the conduct of its nursing home prescreening program (see Appendix I). The Foundation's responsibilities will be to conduct, at least semiannually, a rigorous and effective review of a sample of the site channeling clients. The review will include client assessment records, case plans, and the outcomes of services delivered. It is recognized that due to the medical nature of the Foundation's responsibilities that the scope of its review system will have to be expanded for this project and that components related to non-medical placements will have to be incorporated. Resume's of principals at the Foundation are presented in Section 7.5 along with basic information about that organization.

5.5 Phase I, Task 5: Service Expansion - The elderly in need of community-based long-term care services are likely to have multiple impairments due to chronic disease. Problems created by chronic conditions are complex and overlapping. They may result in the need for a mix of medical, social, economic, and mental health services. Frequently, no single long-term care service is sufficient to meet the multidimensional needs of this population. Services required to maintain the elderly in their home range from home-chore services, transportation, and home repair to skilled medical and nursing care. Even if a variety of services are available, the lack of a single needed service may result in institutionalization.

Present funding for a comprehensive scope and array of community-based services for long-term care is complex, fragmented and in certain areas, such as congregate housing, inadequate. Federal sources of funding long-term care flow from a variety of federal

agencies including Health Care Financing Administration, Office of Human Development Services, Administration on Aging, Social Security Administration, and Public Health Services. Because each of these agencies channels its own funds to the State and local levels, the fragmented funding of the long-term care system is maintained at each level.

Projects, such as the Long-Term Care Channeling Project, must utilize all existing funding resources, however, such projects tend to rely heavily on Title XX and Title XIX funds to provide services and are thus limited to serving a predominantly welfare population, thereby missing the opportunity to serve the private pay and Medicare who may later convert to Medicaid after admission to a nursing home.

The importance of coordinating all existing long-term care services and building upon this base in expanding or developing services cannot be overemphasized. However efficiently this is accomplished, there will be important gaps in arranging a comprehensive package of services for each channeling client. For example, funding for day care (or night care) and repite services are unavailable from any program in Montana. In a family setting where an elderly parent needs constant supervision and attention, family relationships may easily become strained to the point of being unable to cope with the situation. The result is institutionalization. The availability of day care or respite care services to ease the family's burden may prevent nursing home placement.

If Montana is awarded a contract for a Long-Term Care Channeling Demonstration Project, the supplemental money to expand the availability of in-home and community services to channeling clients would be used as a single funding source to allow the local channeling agency the flexibility to cut across eligibility and funding barriers to address the service gaps identified in the following discussion.

5.5.1 Nature and Amount of Services to be Provided with Additional Money - Information from local site channeling proposals and the state pre-admission screening, discharge and alternate care program identify specific service areas in need of expansion and development. The JRB study (final report due July 31, 1980) will further delineate how the people in need of alternative care distribute among the kinds of care that might be available if appropriate funding were available and the cost of such care.

Many of the applicants for long-term care who were assessed by the pre-admission screening team, were found to not need the level of care provided by nursing homes, but did require more supervision and services than could be realistically provided at home. The types of housing facilities which provide less intensive care than nursing homes but which do provide some health and social support services are generally referred to as 'congregate housing'. The lack of this type of facility emerged as the most critical gap in community-based long-term care services in the pre-admission screening program.

Home health care, home chore services, home delivered meals, personal care, day care, respite care, companion service, housing rehabilitation special transportation, and escort services are identified by the local site proposals and the State's experience as being in short supply or lacking. The supplemental money for service expansion will facilitate different approaches to service delivery.

Montana's Helena Comprehealth, demonstrated that para-professionals, supervised by social work staff, utilized in outreach and service delivery, increased the effectiveness of client participation in the program. These workers performed such tasks as seeing that clients kept medical appointments and in some cases provided the transportation. These kinds of services are time consuming and often neglected but have an impact on the effectiveness of a program.

The provision of 'seed' money for new innovative approaches to service expansion and delivery would encourage providers who may not otherwise be willing to take this risk. This money could be available for funding a service delivery until it is demonstrated that client utilization and cost effectiveness of the program would assure its continuation.

In a program such as the Long-Term Care Channeling Project, it can be predicted that the need for certain unique services will emerge from time to time; services that no agency has considered funding. After a review of the individual care plan and a determination that such a service is needed to prevent institutionalization, supplemental money could be utilized to cover these special cases.

It is recognized that all public funding resources for long-term care described in Section 3 of this document be utilized, in addition to any private resources available. Montana's commitment to provide

a continuation of long-term in-home, community and institutional care has also been documented in Section 3.13.

The receipt of the supplemental money to expand services and develop new services has been determined to be a most important variable ensuring the success of a demonstration project. Therefore, Montana's proposal for the demonstration contract award becomes dependent on the award of the supplemental money as well.

5.6 Phase I, Task 6: Relationship to National Assistance Contractor - Either site will need technical assistance related to each of the core channeling services, since the instruments for screening and assessment, the definitions for case managment reporting, and other information elements are being prescribed by either the national evaluation contractor or the SRS technical consultant.

SRS will provide technical assistance in the management of the information system set up by the State, including programming and procedures control. We will also train screening personnel to use the screening instrument and report findings. Both the information system and the screening instrument will have procedures manuals developed for use at the site.

We would expect the national assistance contractor to provide technical assistance in the other technical areas that involve the assessment instrument and reporting requirements. SRS is willing to comply with training requirements set up by the national contractor provided advance scheduling considerations, as presented in Section 6.3.4, are honored.

5.7 Phase I, Task 7: Relationship to National Evaluation Contractor - SRS has had limited previous experience in conducting demonstrations with strong outcome evaluation components. Relevant demonstration project experience is cited in Section 3.8. Both the Delta Dental project and the Comprehealth Project used control and experimental group evaluation designs. These projects had case management components and alternative medical service components that caused experimental group conditions to differ from the control group. At least for the Comprehealth Project, the demonstration indicated better health utilization patterns for the experimental group. It was not determined to what degree either case management or alternative medical services contributed to the difference.

We are prepared to comply with specified evaluation requirements, including the possible utilization of randomized assignment of channeling applicants to experimental and control groups, provided that the control group selection is separated from the experimental group by either geographic or eligibility criteria, and that SRS is allowed to participate with the national contractor in developing the sampling design. SRS cannot allow an applicant, who is otherwise eligible for services that are proximately available, to be denied those services because of the draw of a random number.

SRS will comply with the requirements for use of a common, national contractor specified assessment, client tracking and cost accounting system as indicated in Section 5.4.2. We expect, however, to be involved in the development process, since we will be setting up interim procedures for recording client-specific data, including data from the screening instrument, client assessment form, and care plan, which will be stored in a way that will be retrievable for national evaluation purposes.

5.8 Phase I, Task 8: Interim Report and Phase II Plan - The SRS Project Manager will prepare the interim report and phase II plan in cooperation with the local channeling subcontractor. The interim report will include at a minimum:

- activities of the project during the operational phase;
- problems encountered and solutions;
- community participation in the project; and
- relationships with providers

The detailed operational plan and time line for carrying out Phase II activities will be included.

SRS currently only plans for a waiver for the Medicaid program concerning the state-wideness limitation so that flexibility may be exercised within Medicaid regulations on behalf of eligible recipients in the site without having to establish the same opportunity elsewhere in the State during the demonstration. A reasonable possibility for other waivers concerns allowing Medicaid support for preventive health services not currently covered by regulations.

5.9 Phase II/III - Should the option be availed, SRS would proceed with both Phase II and III by continu-

ing to carry out the basic screening assessment, case management, and review activities developed in Phase I and all required data collection activities. We would anticipate that the caseload projections for Phase I would continue into the following phases. Maintenance of relationships with the national technical assistance and evaluation contractors established during Phase I would continue. SRS would attend the four meetings during Phase II and the two meetings during Phase II to be held in Washington, D.C. The interim and service reports scheduled for months 36, 48, and 54 will be prepared as will the final report.

5.10 Alternate Proposal - SRS proposes an alternate to do an 18-month follow-up survey and annual surveys thereafter, of the sample used to identify the number of functionally impaired elderly in Montana using the Geriatric Functional Rating Scale developed by Grauer and Birnbom. The initial survey was conducted between January and May, 1980.

Three population groups aged 65 and over were sampled with the survey instrument. A total sample size of 1500 was proposed as a goal and was achieved. Each sub-population group sample contains 500 respondents. The three population groups are: Medicaid eligibles in nursing homes, Medicaid eligibles not in nursing homes, and non-Medicaid elderly residing in boarding homes. The third group was chosen to represent the non-Medicaid elderly. This group was chosen to represent the non-Medicaid elderly since the population of all HUD-subsidized housing for the elderly is known, which allows for random sampling on a regional basis.

A random cluster sampling approach was utilized for all three population groups. Three hundred respondents were sampled from each of the three groups. The random cluster sampling procedure within each region was designed to reflect the proportion of elderly living within urban counties within each region. A sequence of counties was selected randomly within each region, reflecting urban and rural sampling requirements. The utilization of counties as clusters preserves the random sampling requirement to present estimates of population statistics at the regional and state level. The cluster approach saved considerable travel and personnel time expense; or (since the project budget was fixed) allowed for the collection of more surveys than a random sample would have provided. Non-random sampling procedures might have realized a much larger number of surveys completed; however, statistical estimates of population

characteristics are invalid under such procedures, unless a census is taken.

This sampling approach has produced a study of unique characteristics. Perhaps the most significant is that pointed out by Dr. Linda Noelker at The Benjamin Rose Institute regarding a rigorous test of the GFRS instrument. One thousand of the respondents to this study form a unique baseline of noninstitutionalized, randomly selected community aged who can be followed at one year intervals to validate the predictive ability of the instrument used. Published 'validation' studies have utilized aged who are either institutionalized or are candidates for institutionalization. A report of initial survey findings and Dr. Noelker's comments are included in Appendix J.

The follow-up survey would achieve two things:

1. The validation of the GFRS for the non-institutionalized randomly selected community aged, and

2. an estimate of the change in functional need of Montana's elderly.

We estimate that this alternate will involve one person year over a six-month period beginning approximately nine months after the channeling contract is awarded, with this same allocation being required each year of the demonstration thereafter.

6. MANAGEMENT PLAN

6.1 Schedule of Activities - The schedule lists precontract activities and contract activities. The schedule for precontract activities shows calendar days from submission of the channeling proposal (June 13, 1980). The schedule for contract activities shows calendar days from date of award (assumes September 30, 1980.)

Precontract activities are listed (1) because the coordinator of Montana's existing long-term care planning with the channeling demonstration needs to be demonstrated, and (2) because lead time is needed to hire staff and contract with consultant in order to be ready for the extensive activities required immediately after the award is made.

	PRECONTRACT ACTIVITIES	DAYS FROM APPLICATION
6.1.1	LTC PLANNING BOARD	
1.1	Distribute copies of Channeling proposal and letters of appointment to the LTC Planning Group	10 days
1.2	Hold organizational meeting of the LTC Planning Group	20 days
6.1.2	CONSULTANT SERVICES	
2.1	Prepare RFP for consultant services	10 days
2.2	Receive proposals in response to RFP	40 days
2.3	Select consultant (60-day effective bid)	50 days
2.4	Consultant contract begins (contingent on award)	110 days
6.1.3	STATE STAFF	
3.1	Prepare state level job descriptions employee selection criteria, and FTE budget allocation	50 days
3.2	Advertise state position (contingent on notice of award)	80 days
3.3	Interview and select state staff	95 days
3.4	State staff on the job	110 days
6.1.4	STATE LTC PLAN	
4.1	Receive final report on Alternatives Study	50 days
4.2	LTC planning group review final report and hear presentation by Alternatives Study consultants	65 days
4.3	Develop initial State LTC Plan (State legislative focus)	95 days
4.4	LTC Planning Group review initial plan	110 days
4.5	Deliver Initial LTC Plan to the Governor	140 days

	PHASE I CONTRACT ACTIVITIES	DAYS FROM AWARD
6.1.5	PHASE I, TASK 1: LTC PLANNING	
5.1	Composition and creation of LTC Planning Group	see 6.1.1
5.2	Development of State LTC Plan	
	A. Initial LTC Plan	see 6.1.4
	B. Prepare "state-of-the-art" assessment	210 days
	C. Develop 1st update of LTC Plan (draft)	240 days
	D. Hold public forum on LTC Plan	270 days
	E. Deliver LTC Plan to the Governor	300 days
	F. Approved LTC Plan forwarded to government project officer	360 days *
5.3	Site development/LTC Planning Group	
	A. Review draft site reports for state/local linkage	30 days
	B. Hold public forum on Anaconda site plan	30 days
	C. Hold public forum on Missoula site plan	35 days
5.4	Meetings of the LTC Planning Group	
	A. Organizational Meeting	see 6.1.1.2
	B. 2nd meeting (review Alternative Study)	see 6.1.4.2
	C. 3rd meeting (review initial LTC Plan and public forum - Anaconda Site)	see 6.1.4.4 & 6.1.5.3.B
	D. 4th meeting (public forum - Missoula site)	see 6.1.5.3.C
	E. 5th meeting (review state-of-the-art assessment)	see 6.1.5.2.B
	F. 6th meeting (public forum - updated LTC plan)	see 6.1.5.2.D
6.1.6	PHASE I, TASK 2: SITE PLANNING	
6.1	Prepare draft report for each site	25 days
6.2	Review with LTC Planning Group and hold Ananconda public forum	see 6.1.5.3.B
6.3	Hold Missoula public forum	see 6.1.5.3.C
6.4	Prepare proposed subcontracts	45 days
6.5	Deliver final report and proposed subcontracts for each site to goverment project officer	60 days *
6.1.7	PHASE I, TASK 3: SITE DEVELOPMENT	
7.1	Government selection of a site	90 days
7.2	Effect subcontract with local lead agency	95 days
7.3	Hire project administrative personnel	135 days

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* Contract deliverable
** Dependency: national evaluation contractor
*** Dependency: national technical assistance contractor

7.4	Design Channeling linkages including personal specifications and case finding/ screening/referral	165 days	
7.5	Develop project governance mechanisms and public education and participation opportunities	180 days	
7.6	Develop formal and informal agreements with agencies and providers	180 days	
7.7	Develop screening instrument and procedures		
	A. Design instrument	180 days	
	B. Pretest instrument	210 days	
	C. Write procedure manual	240 days	
	D. Train users	365 days	
7.8	Develop informed consent procedures	240 days	
7.9	Hire channeling staff	325 days	
7.10	Pretest client assessment instrument and tracking and cost reporting systems	365 days	**
7.11	Develop procedures for internal research and evaluation to improve project performance, including state data collection and reporting systems	240 days	
7.12	Submit interim report	270 days	*
7.13	Government Project Officer approval of report	365 days	
6.1.8	PHASE I, TASK 4: CHANNELING IMPLEMENTATION		
8.1	Initiate Channeling services	365 days	
8.2	Design service monitoring and client reassessment	240 days	
8.3	Design and arrange for services audit and program review procedures	460 days	
8.4	Conduct and report 1st review	540 days	*
8.5	Conduct and report 2nd review	730 days	*
6.1.9	PHASE I, TASK 5: SERVICE EXPANSION		
9.1	Identify potential gaps in service	365 days	
9.2	Develop new services and procedures	460 days	
9.3	Identify needy clients	460 days	
9.4	Initiate new services	460 days	
9.5	Submit 1st summary service report	540 days	*
9.6	Submit 2nd summary service report	730 days	*
6.1.10	PHASE I, TASK 6: NATIONAL T.A.		
10.1	Participate in information sharing network	N/A	***
10.2	Participate in workshops on assessment and case management	N/A	***
10.3	Participate in on-site TA for site development and use of national forms and system	N/A	***
6.1.11	PHASE I, TASK 7: NATIONAL EVALUATION		
11.1	Develop interim procedures for recording client-specific data	240 days	
11.2	Coordinate with national evaluation contractor on design of random assignment in control group	N/A	**

11.3	Assist national evaluation contractor in data collection and development of assessment instrument	N/A **
6.1.12	PHASE I, TASK 8: PHASE II PLAN	
12.1	Government project officer provides range and scope of waiver that will be permitted	420 days
12.2	Submit interim report and Phase II plan to government project officer	600 days *
6.1.13	PHASE I, TASK 9: NATIONAL DATA & REPORTING	
13.1	Develop state data collection and reporting system	240 days, see also 6.1.11.1
13.2	Coordinate with national data and reporting system	N/A **

	PHASE II CONTRACT ACTIVITIES	MONTHS FROM AWARD
6.1.14	PHASE II, TASKS 1-3: PHASE I EXTENDED Continued Operations	On-going
6.1.15	PHASE II, TASK 4: FEDERAL MEETINGS Four (4) meeting in Washington D.C.	N/A
6.1.16	PHASE II, TASK 5: INTERIM REPORTS	
16.1	Submit 3rd summary service report (see 6.1.9)	30 months *
16.2	Submit 3rd review report (see 6.1.8) and 4th summary service report	36 months *
16.3	Submit 5th summary service report	42 months *
16.4	Submit 4th review report, and 6th summary service report	48 months *
6.1.16	PHASE II, TASK 6: PHASE III PLAN	
16.1	Submit Phase III plan	44 months *
16.2	Government decision on plan	48 months

	PHASE III CONTRACT ACTIVITIES	MONTHS FROM AWARD
6.1.17	PHASE III, TASKS 1-3: PHASES I and II EXTENDED Continued operations and phase out of federal funding	On-going
6.1.18	PHASE III, TASK 4: FEDERAL MEETINGS	
18.1	Two (2) meetings in Washington D.C.	N/A
18.2	Submit 7th summary service report	54 months *
6.1.19	PHASE III, TASK 5: FINAL REPORT	60 months *

6.2 Allocation of Staff - Exhibit 6-1 displays the manpower allocations for each staff member and for the

MONTANA CHANNELING DEMONSTRATION
STAFF / CONTRACTOR TIME IN DAYS

	* JACK DORNER	SRS MGR. & SEC.	SRS CONSUL.	MT FOUND. FOR MED. CARE	SITE MGR. & SEC.	DATA ENTRY	SCREEN-ER	CASE ASSESS-MENT/ MGMT. TEAM	TOTAL	TOTAL PERSON YRS.
Precontract Tasks										
1. LTC Planning Group	2									
2. Obtain Consult. Services	3									
3. Hire State Staff	5									
4. Develop Initial LTC Plan	20									
Phase I - Yr. 1 & 2										
1. LTC Planning	15	210	50						260	1.00
2. Site Planning	15	65	130						195	0.75
3. Site Development		115	15		325		20	110	585	2.25
4. Implement Channeling		390	40	130	520		260	1300	2640	10.15
9. Data Entry Option						65			65	0.25
Alternate			260						260	1.00
Phase II - Yr. 3		390	40	130	520		260	1300	2640	10.15
Data Entry Option						130			130	0.50
Alternate			260						260	1.00
Phase II - Yr. 4		390	40	130	520		260	1300	2640	10.15
Data Entry Option						130			130	0.50
Alternate			260						260	1.00
Phase III - Yr. 5		390	40	130	520			1065	2145	8.25
Data Entry Option						130			130	0.50
Alternate			260						260	1.00
TOTAL		1950	355	520	2405		800	4965	11.105	42.70
Data Entry Option						455			455	1.75
Alternate			1040						1,040	4.00

* Days not inc. in totals

State's contractor for each major activity represented in section 6.1. A total of 42.70 person years are indicated. Precontract activities require 30 person days which are entirely state staff. Another 30 person days are contributed during the early stages of Phase I.

If the government elects Task 9, an additional 1.75 person years will be required for data entry.

Notice should be taken that 4 person years are allocated to an alternate included in this proposal (see Section 5.10).

6.3 ASSURING TASK PERFORMANCE

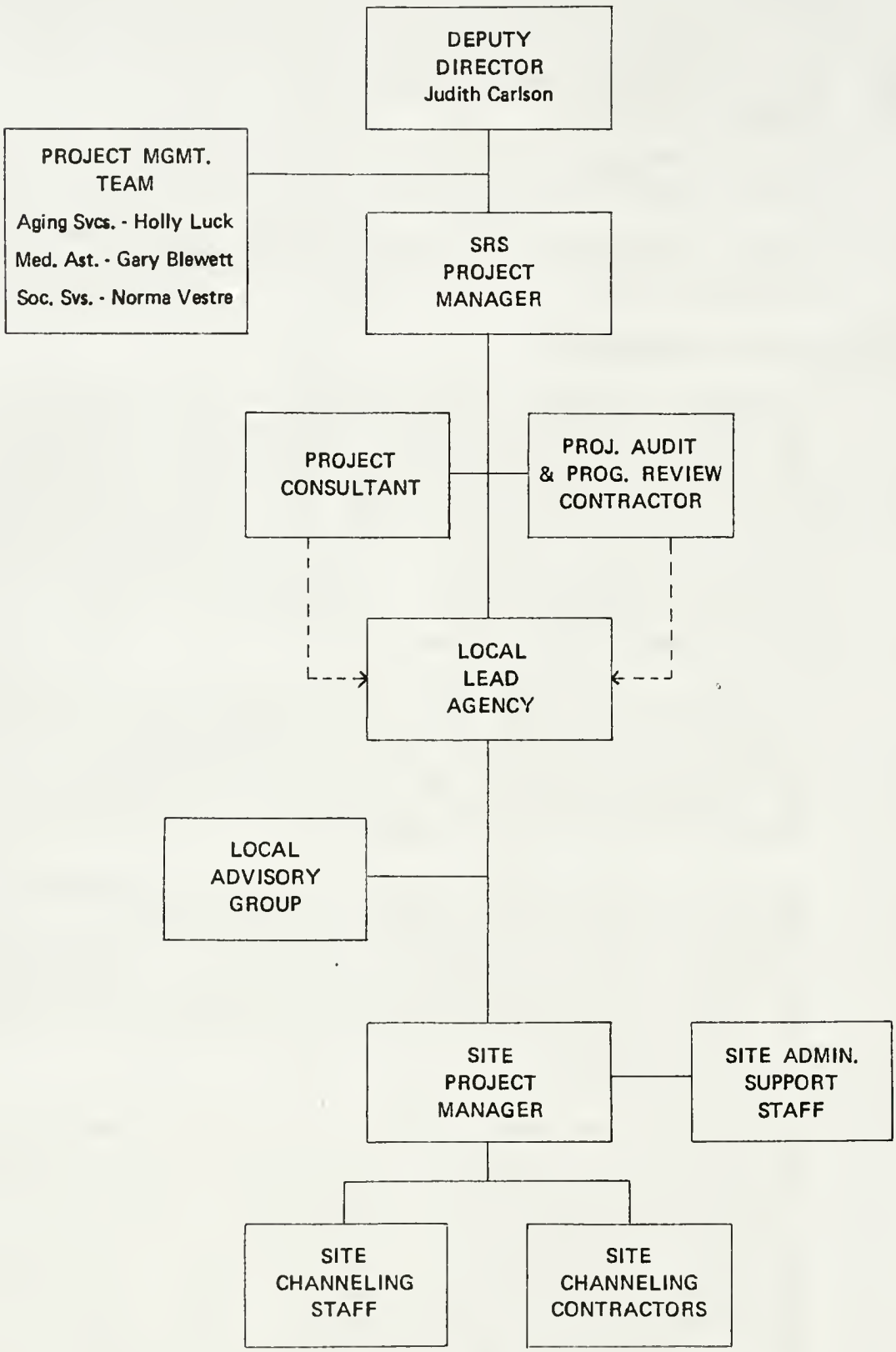
6.3.1 Management Control and Authority - The Governor of the State of Montana has designated the Montana Department of Social and Rehabilitation Services (SRS) as the lead agency for administering the proposed project contract between the federal government and the state. Keith L. Colbo, Director of SRS, as the authorized signator, has designated Judith Carlson, Deputy Director of SRS, to coordinate and supervise project tasks. An organization chart for SRS is presented in Appendix H.

All tasks performed under this contract, including tasks performed under any subcontract, will be administered in accordance with the provisions of the contract, the State of Montana Operations Manual, and the Montana Department of Social and Rehabilitation Services Administrative Manual.

6.3.2 Lines of Supervision and Internal Coordination - Exhibit 6-2 presents lines of supervision and coordination within SRS and with subcontractors. Tasks will be performed under the supervision of SRS Deputy Director, Judith Carlson. The Project Manager will be a state employee, hired in accordance with State Personnel policies, and will report directly to the Deputy Director.

The Project Management Team is currently organized to prepare and review the channeling project proposal. The team will function under the contract as a vehicle for day-to-day coordination and review of project management. In addition to the Deputy Director, who chairs the Team, the Project Management Team has three members who represent SRS responsibilities for Titles III, XX, and XIX. Holly Luck is the Chief of the Aging Services Bureau and is responsible for administration of the Title III program. Norma Vestre is Chief of the Social Services Bureau and is

MONTANA CHANNELING DEMONSTRATION
LINES OF SUPERVISION AND COORDINATION



responsible for the administration of the social service aspects of the Title XX program. The Deputy Director is charged with the overall coordination of the Title XX program and is able to represent the administrative concerns of other bureaus involved in the administration of the Title XX program. The Economic Assistance Division, which is responsible for the administration of the Title XIX program in addition to other economic assistance programs, is undergoing reorganization. Gary Blewett, Supervisor for Financial and Institutional Service for the Title XIX program, represents the Division at this time. The resumes for each team member are included in Section 7.5.

SRS proposes to subcontract certain research and technical assistance responsibilities with a consulting firm that has demonstrated capabilities in long-term care research and operations analysis. Due to the nature and scope of the proposed subcontract, SRS cannot sole source this opportunity. For this reason, resumes of consulting principals are not included in this proposal. In their stead, are the qualification requirements for a successful bidder and the proposed scope of work, which are presented in Section 7.3.

SRS will also subcontract with the proposed local lead agency for the channeling activities to be conducted under the terms of this proposal. The Project Manager will direct the technical efforts under both subcontracts. However, the Project Manager will provide no supervisor or instructional assistance to subcontractor personnel; rather, the Project Manager's responsibility is to provide the subcontractor with working data to aid in the performance of contract requirements.

Technical assistance concerning channeling project requirements will be provided the local lead agency and its designated administrative staff and channeling delivery mechanism. The federal government will provide this assistance through its national technical assistance contractor to further the interests of the national demonstration. The relationship of the national technical assistance contractor with the local lead agency is presented in Section 6.3.4. SRS will also provide technical assistance through its contractor to enable SRS to carry out its administrative responsibilities, with particular attention on design and implementation of the screening instrument and the collection of data.

In the case of both proposed sites, the local lead agency will have a local advisory group to work with the local agency's day-to-day management of the project and to facilitate coordination of multi-agency efforts on behalf of the channeling effort.

Each of the proposed local lead agencies are to establish a full time site project manager who will supervise the project's screening person and the assessment and case management teams, and the administrative staff. Should there be subcontracts for services, the project manager will administer those.

6.3.3 Coordination with Other Agencies - The coordination with other agencies is indicated in Section 5.1.

6.3.4 Coordination with National Channeling Contractors - Exhibit 6.3 shows the relationship among the various contracting parties under the demonstration. There are four possible sources of project direction that could input to the local lead agency. The potential for conflict and confusion is great unless mechanisms for coordination are assured.

Conditions for Montana's participation in the channeling demonstration are:

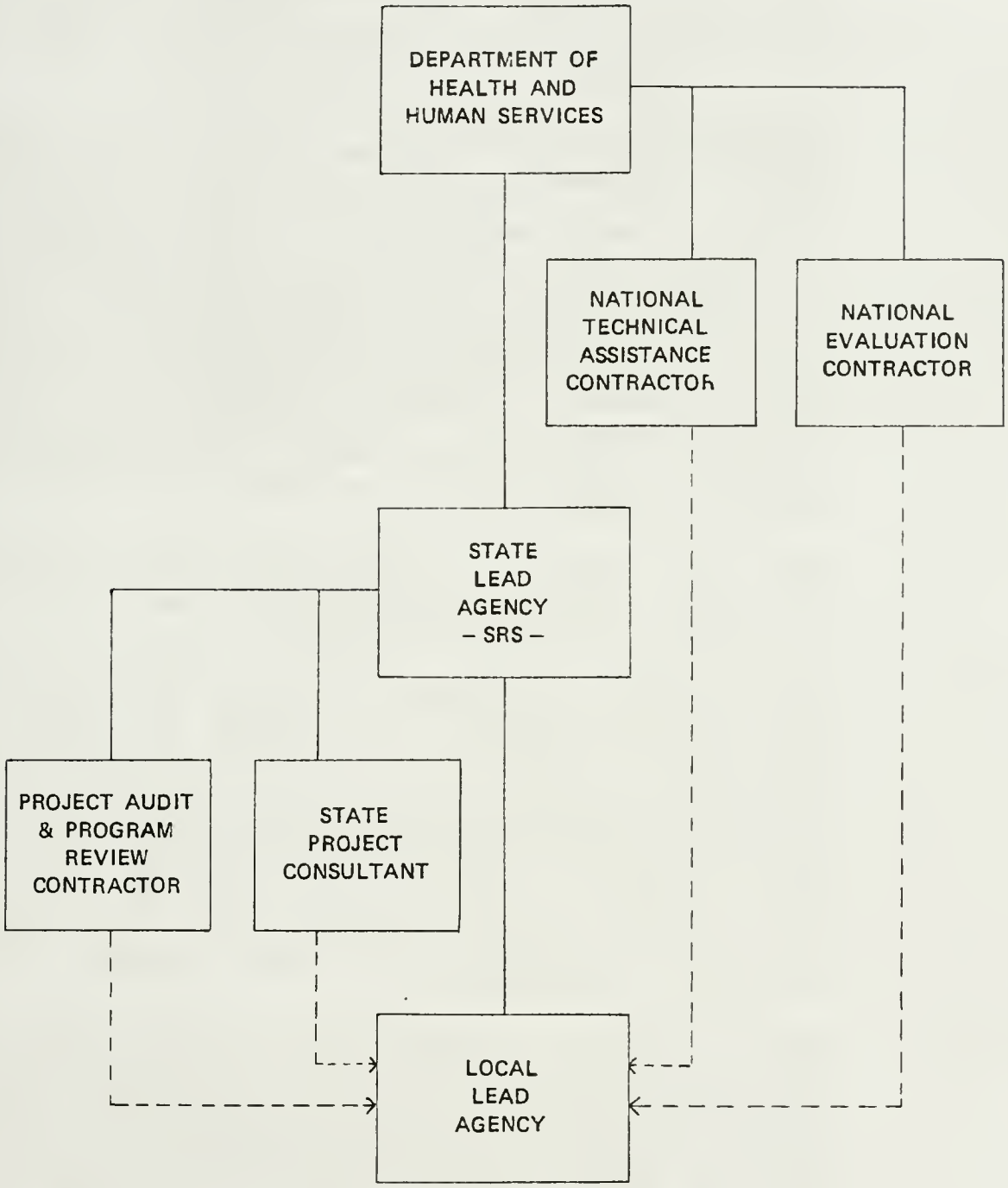
1. SRS, the SRS subcontractor, the local lead agency, and the national evaluation contractors will work out a Montana-specific joint schedule of activities as they may become operational in advance of a contractor doing any on-site work or requiring work by the local lead agency not referenced specifically and scheduled explicitly in the SRS subcontract with the local lead agency.

2. The schedule of activities will identify the activities, their timing, the principal parties involved in their performance, and the advance preparation required before on-site work may begin for the two national contractors and the SRS contractors.

3. The schedule of activities will project at least twelve (12) months in advance, to be updated and extended each quarter.

4. The schedule may be amended with two weeks advance notice to both SRS and the local lead agency, and provided that none of the principal's objectives or major activities is jeopardized by the change.

MONTANA CHANNELING DEMONSTRATION
COORDINATION WITH NATIONAL CONTRACTORS



SRS will adhere to these conditions and will enforce them with its consulting subcontractor and the local lead agency subcontractor. SRS would expect the Department of Health and Human Services to similarly enforce them with its national contractors.

6.3.5 Task Performance Monitoring - The SRS Project Manager will employ a computer-based project control system (PC/70) to identify each project task and subtask, their relative priority within each quarter's time frame, the key actors, and their hours budgeted and expanded. The personnel time allocations and product completion schedules will be measured against actual performance to allow measurement of project program and early identification of needed schedule changes. Reporting will be weekly and will include tasks and responsibilities at both the state and local levels. Executive summaries will be produced for the project management team's periodic review. More detailed and frequent reports will be available to both the state and local project managers.

The PC/70 system is already part of SRS's library. There will be a monthly processing charge, which is included in the business proposal.

6.3.6 Services Audit and Program Review - SRS will arrange for semiannual audits and reviews of channeling services as scheduled in Section 6.1.8.3, and described in Section 5.4.3. The SRS Project Manager will summarize the audit and review information in a report with recommendations and submit to both SRS's Project Management Team and the Planning Group for their review and comment. The Planning Group and Project Management Team responses will be incorporated in final reports and submitted to the Federal Department of Health and Human Services as a scheduled in Section 6.1.

6.3.7 Fiscal Control - All funds received and expended by SRS will be accounted through the State Budgeting and Accounting System (SBAS). A project specific responsibility center will be set up to maintain accounting control of both State direct expenditures and payments to subcontractors. Local site expenditures will be further accounted at the site through a procedure defined by SRS.

6.3.8 Transition: Precontract to Contract Activities - Section 6.1 indicates that should Montana be awarded a contract under the channeling demonstration, there would be a scaling up of State LTC planning activities to allow for the more intensive effort the demonstration would allow. There is also some con-

tingent preparation to allow for a fast start once the contract is awarded.

This requires a transition procedure to assure that the precontract tasks are performed and that Montana SRS can honor its bid obligations. To this end, SRS is assigning 50% of Mr. Jack Dorner's time to serve in the capacity of SRS Project Manager during the precontract and transition period until the regular project manager is hired or this proposal is turned down. Mr. Dorner's duties are closely related to this project in any case, since he is the policy coordinator for the Medicaid nursing home prescreening program (see Appendix I) and liaison with the Alternatives Study Task Force (see Section 5.1). Mr. Dorner is one of the principal authors of this proposal. His resume' is included in Section 7.4.

7. STAFFING PLAN

7.1 State Level Staffing - There will be one and a half (1½) full time equivalent (FTE) employees hired by SRS out of the proposed project funds. Exhibit 7.1 presents their position within the proposed project management structure.

The SRS Project Manager will be a full time position, to be advertised for and hired according to the schedule presented in Section 6.1.3. The Project Manager will report to the SRS Deputy Director on project performance, and within the scope of the project will have a large degree of independence to initiate action and organize resources to accomplish project objectives. Major responsibilities will be to:

1. negotiate and monitor project subcontracts,

2. maintain project fiscal and management reporting requirements,

3. prepare or cause to be prepared deliverables called for in this proposal,

4. organize the agendas and information for meetings of the Project Management Team and the Planning Group,

5. make public presentations and represent SRS in negotiations or conferences concerning the project, and

6. supervise the secretary.

This position will be classified as a Program Manager V under State of Montana personnel procedures. A job classification description is included in Section 7.4

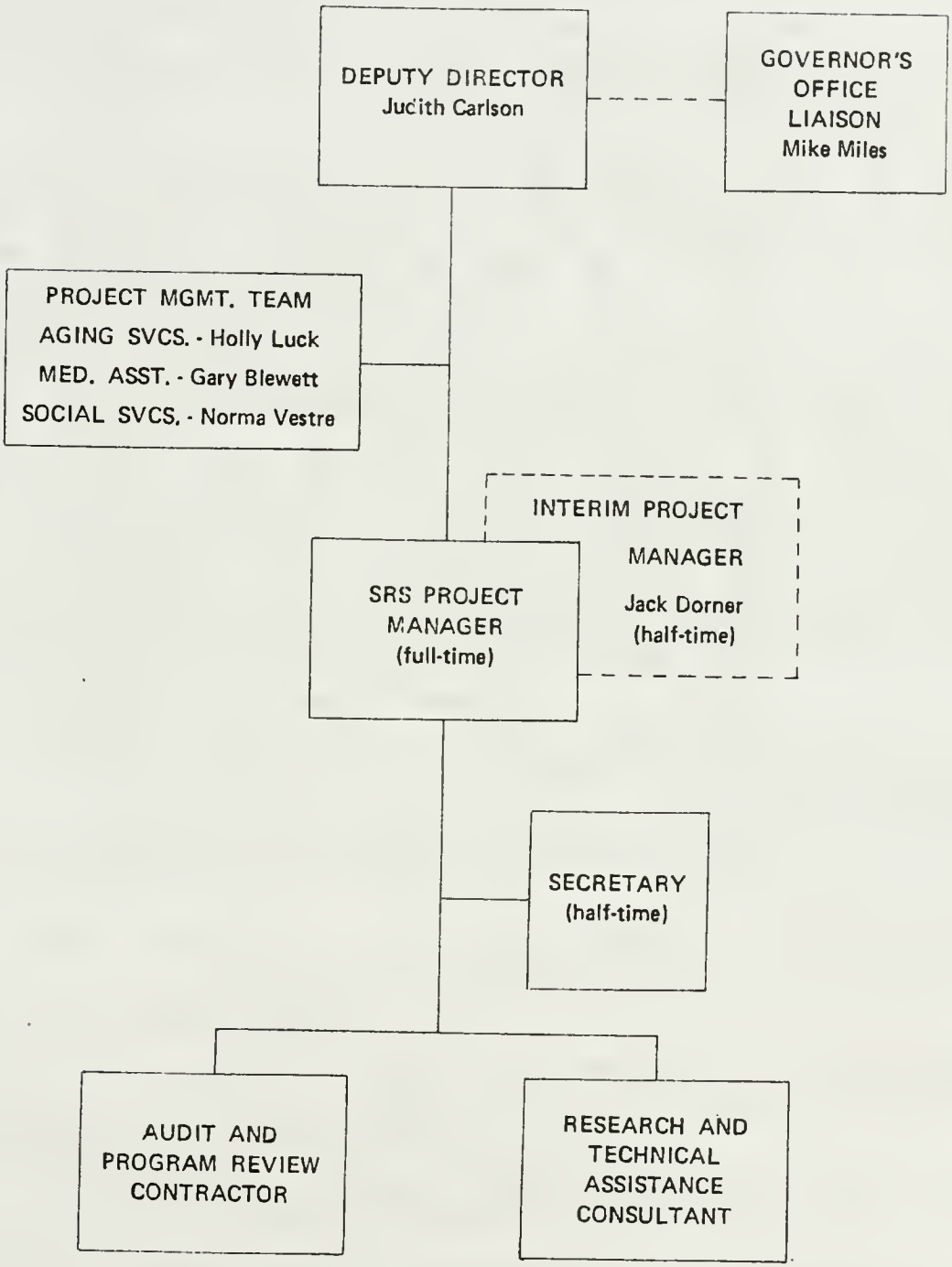
The secretary's position is half time, to be advertised for and hired according to the schedule presented in Section 6.1.3. The secretary will report to the SRS Project Manager and will have the responsibility for:

1. maintaining project files,

2. typing or arranging for typing with the SRS Word Processing Center all project correspondence, forms and reports called for at the state level, and

EXHIBIT 7-1

MONTANA CHANNELING DEMONSTRATION
STATE LEVEL STAFFING PLAN



3. take calls and arrange appointments for the Project Manager.

This position will be classified as a Secretary II under State of Montana personnel procedures. A job classification description is included in Section 7.4.

Since some of the proposed project tasks will be implemented before the State may be awarded a contract, an interim project manager, Mr. Jack Dorner, has been appointed as discussed in Section 6.3.7. Mr. Dorner will prepare or arrange for the preparation of the tasks listed in Section 6.1.1 through 6.1.4. He will be assigned half-time at no cost to the proposed project during this period. Mr. Dorner's resume' is included in Section 7.4.

As referenced in Section 6.3.2, SRS proposes to subcontract certain research and technical assistance responsibilities with a consulting firm that has demonstrated capabilities in long-term care research and operation analysis. Due to the nature and scope of the proposed subcontract, SRS cannot sole source this opportunity. For this reason, resumes of the consulting principals are not included in this proposal. In their stead, are the qualification requirements for a successful bidder, and the proposed scope of work which are presented in Section 7.3.

The contract for services will specify five components:

- Design and install, at the local site, a screening instrument and procedure.
- Work on site planning during the first two months after contract award.
- Design and install a project information system for purposes of supporting site service operations and delivery, and supporting SRS subcontract management requirements.
- Provide analysis relevant to the state-of-the-art assessment for long-term care planning.
- Conduct an 18-month follow-up survey and annual surveys thereafter of the sample used in the State's LTC Alternatives Study.

The last item will be bid as an alternate as it is in the business proposal for this project.

SRS will subcontract with the Montana Foundation for Medical Care for audit and program review activity as referenced in Section 5.4.3.

Other individuals who will also be working regularly with the project are also presented in Exhibit 7.1. These people have responsibilities for setting policy direction and monitoring performance. None of them are included as a cost to the project. The time they will expend on behalf of the project will be considered a responsibility consistent with their existing duties. Resume's for each person are included in Section 7.4.

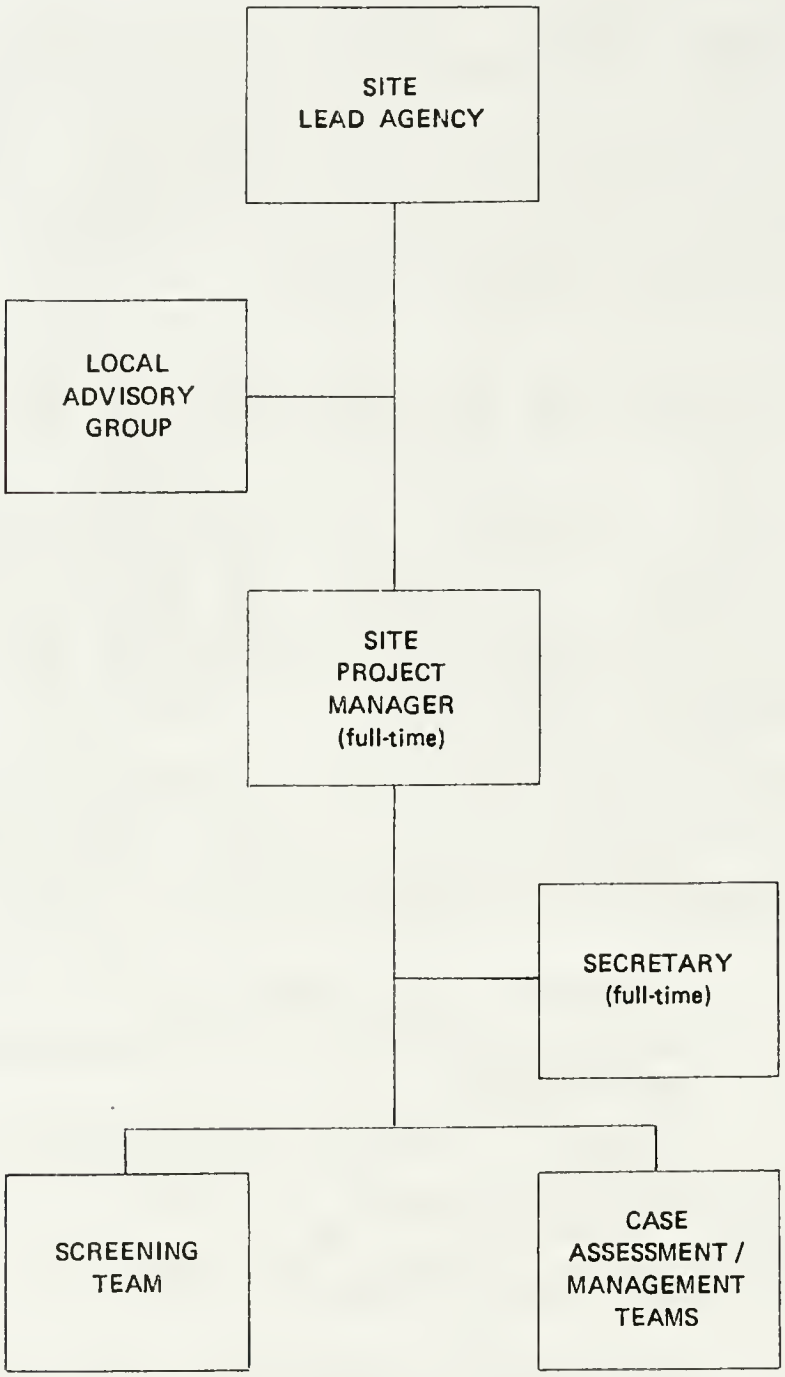
7.2 Site Staffing - The staffing plan for direct delivery of channeling services is the same for both sites. However, the relationship between the Site Lead Agency and the Site Project Manager is different. Exhibits 7-2 and 7-3 show the staffing plans for each site. In Anaconda, the Site Project Manager would be a staff member of the lead agency (the Aging Area Officer). In Missoula, the Site Project Manager would be a staff member of an agency (the City-County Health Department) to which the Site Lead Agency (the Missoula County Council on Aging) subcontracts all channeling functions.

For either site, the Site Project Manager will, within the scope of the project, have a large degree of independence to initiate action and organize resources to accomplish project objectives. Major responsibilities will be to:

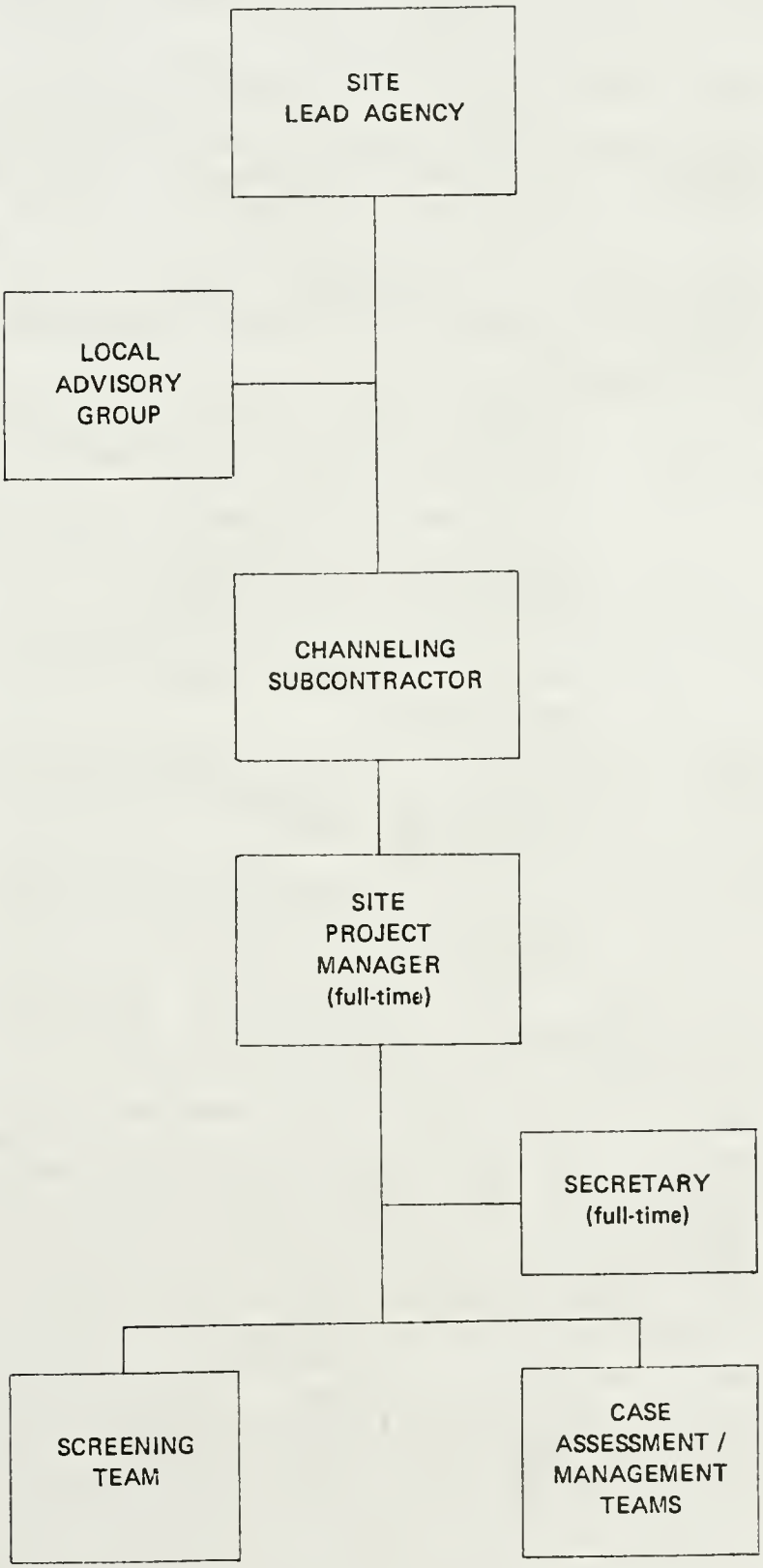
- negotiate and monitor project subcontracts,
- maintain project fiscal and management reporting requirements,
- prepare or cause to be prepared deliverables called for in the contract between SRS and the Local Lead Agency,
- organize agendas and information for local advisory group meetings,
- make public presentations and represent the Local Lead Agency in negotiation or conferences concerning the project, and
- supervise the client assessment terms, the case management teams, and the secretary.

EXHIBIT 7-2

MONTANA CHANNELING DEMONSTRATION
ANACONDA SITE STAFFING PLAN



MONTANA CHANNELING DEMONSTRATION
MISSOULA SITE STAFFING PLAN



The secretary's position is full-time. The secretary will report to the Site Project Manager and will have responsibilities that are similar to those for the SRS project secretary.

Both positions will be classified and hired according to local conventions. The classification descriptions included in Section 7.4. for the SRS Project Manager and Secretary represent the same type of qualifications that will be involved at the site.

Based upon the population data, one full time screener will be employed and will be under the direct supervision of the subcontractor. The screener will:

- collect information on the nature of the client's problem, and available resources,
- utilize the Geriatric Functioning Rating Scale to determine if the client is appropriate for referral to the channeling project or other services,
- refer to the channeling project, if appropriate,
- refer to more suitable services if determined inappropriate for channeling assessment, and
- develop linkages with other community agencies to facilitate the referral process.

Client assessment teams will be two-member teams -- a registered nurse and a social worker.

One full time social work position will be allocated to the assessment team function while three full time social work positions will be assigned to the case management positions. The four social workers, however, will act as revolving team members on the assessment team and continue as the case management of clients screened, thus providing a continuum of service with one contact person. The assessment team will provide a comprehensive assessment of each client referred utilizing a uniform assessment tool to be developed by the government project officer and the contractor. The assessment team will be supervised by the Site Project Manager.

The comprehensive assessment will include:

- a medical evaluation,
- an evaluation of the client's ability to perform activities of daily living,
- a psychosocial evaluation relative to the client's emotional condition, mental functioning, social adjustment, and communication ability,
- an evaluation of the individual's and family's preferences and life styles,
- ability and willingness of families to provide various types of assistance,
- assessment of the individual living conditions, and the
- individual's financial status.

Confidentiality will be maintained throughout the channeling procedures.

Case management will be provided by three full time social work positions. The primary responsibility of these positions is to translate client need into services. A care plan, involving the client and the client's family (or guardian, if appropriate) identifying problems, goals to be achieved, services to be utilized and costs of services, will be prepared utilizing a standard form. The case managers will arrange for services, assure that services prescribed in the care plan are being provided and reassess the client's situation after any major known change in a client's situation and in any case not less often than six-month intervals.

All positions will be classified and hired according to local conventions. The classification descriptions included in Section 7.4 for the SRS Project Manager, professional nurse, social worker, eligibility technician (screener), and secretary represent the same type qualifications that will be involved at the site.

7.3 SRS Technical Consultant Specifications - SRS will have several obligations under the proposal for the demonstration that will require technical expertise not currently available on its staff. The required specialization is best obtained through a contract for consultant services. SRS will solicit a qualified consultant through a request for proposals.

Eligible offerors must be able to demonstrate the following in their proposals:

- Working knowledge of the Geriatric Functional Rating Scale developed by Grauer and Birnbom.
- Famliarity with the functional need of Montana's elderly.
- Understanding of the channeling concept and the literature relevant to long-term care as they might be applied in Montana.
- Technical knowledge of computer based information systems to be used for rural community health and social service programs.
- Working knowledge of sample surveying techniques and the interpretation of statistics derived from such samples as they reflect the population they are intended to represent.
- Working knowledge of evaluation research designs involving experimental and control groups.

The scope of work to which offers must respond is:

- Design and install, at a local site, a screening instrument based on the Geriatric Functional Rating Scale developed by Grauer and Birnbom with additions as recommended in consultant report #4 for the State's Alternatives Study.
- Prepare all technical and service delivery information required for the report in Task 2 of Channeling RFP for two proposed Montana channeling sites within a two-month period.
- Design and install a project information system for purposes of supporting site service operations and delivery, and supporting SRS management requirements. Training both SRS and local staff in the operation of the system and preparing a users manual will be required. Analysis of information requirements and coordination with national contractor requirements and proposed products will be necessary.

- Provide analyses of the state-of-the-art assessment for long-term care planning as input to the development of the State's long-term care plan. Utilization of information developed in consultant report #1 and the impending final report for the State's Alternatives Study will be expected.

- Conduct an 18-month follow-up survey and an annual survey thereafter of the sample used in the State's Alternatives Study. Determine the validity of the Geriatric Functional Rating Scale as a predictive instrument for non-institutional, randomly selected aged. Report findings and compare trends.

SECTION 7.4

MONTANA FOUNDATION
FOR
MEDICAL CARE

montana foundation for medical care

P O. BOX 5117, 2717 AIRPORT WAY HELENA, MONTANA 59601

TELEPHONES (406)-443-4020 1-(800)-332-3411

President
Sterling R Hayward, M D
Billings

Vice President
John A Ross, M D
Great Falls

Secretary
Richard W Beighle, M D
Missoula

Treasurer
Thomas W Korb, M D
Billings

Directors
Lindsay M Baskett, M D
Livingston

E E Bertagnolli M D
Three Forks

James W Crichton, M D
Helena

Merle D Fitz M D
Scobey

John C Hanley M D
Great Falls

Dwight R Hiesterman M D
Helena

Marcus A Johnson, M D
Choteau

C G McCarthy M D
Missoula

Wilfred S Miller, M D
Whitefish

John A Newman, M D
Butte

Stuart A Reynolds M D
Hays

Richard R Sabo M D
Bozeman

Robert M St John M D
Butte

Ronald H Smith M D
Billings

Robert R Whiting M D
Hardin

A Lewis Vadheim M D
Miles City

Wallace S Wilder M D
Kalispell

Charles D Hundley Ph D
Executive Director

John W McMahon M D
Medical Director

June 10, 1980

Mr. Keith Colbo, Director
Department of Social and
Rehabilitation Services
P. O. Box 4210
Helena, Montana 59601

Dear Mr. Colbo:

We have reviewed certain aspects of Montana's Long Term Care Channeling Demonstration Project. In addition, Mr. Blewett of your staff has discussed the Foundation's role in more detail with our Executive Director and Joyce Steffeck, R.N., Facilities Review Manager. The Foundation agrees to serve as the agency to independently evaluate the effectiveness of the system for at least a sample of agency clients.

Although all actions of this nature are subject to approval by our twenty-one member physician Board of Directors, we will describe our involvement to them at our next meeting in July and indicate staff support.

Sincerely,

John W. McMahon, M.D.
Medical Director

Charles D. Hundley, Ph.D.
Executive Director

JWMCDH/jp

Montana Foundation for Medical Care

The Montana Foundation for Medical Care (MTFMC) is a private nonprofit corporation established in 1973 by the Montana Medical Association with the general objective of assuring the citizens of Montana the highest quality medical care at the most reasonable cost through the mechanism of peer review education.

The MTFMC is governed by a twenty-one member physician Board of Directors, elected by the physicians of Montana. To provide on-site service, the MTFMC has staff located in numerous cities throughout the state. In 1975 the MTFMC was designated by the Secretary of the United States Department of Health, Education and Welfare as the Professional Standards Review Organization (PSRO) for the entire state.

Examples of other groups or organizations utilizing the Foundation's services include the State Department of Social and Rehabilitation Services, State Department of Health and Environmental Sciences, Indian Health Service, various hospitals and county welfare departments, Workers' Compensation Division of the State Department of Labor and Industry. Negotiations are also currently underway with private insurance carriers.

Throughout its programs of Facilities Review, Medical Audit, Medicaid Claims Review, Prior Authorization and Pre-admission Screening, the Foundation comes into contact with every acute and long term care facility in the state on an almost daily basis.

RESUME

Personal

Name: Mary Joyce Steffeck

Address: 1226 Peosta
Helena, MT 59601

Phone: (Home) 443-2154 (Office) 443-4020

Education

Carroll College, Helena, Montana Diploma Nursing	9/52 to 5/55
Carroll College, Helena, Montana B.S. Nursing Education	9/55 to 5/57

Professional Experience:

Place	Date	Description of Responsibilities
Montana Foundation for Medical Care	3/78 to present	Manager Utilization Review Supervises all utilization revi programs at the Foundation
Montana Foundation for Medical Care	11/75 to 2/78	Supervisor Long Term Care Developed, implemented and supervised long term care program
School District I	70-71	Instructor at Vo-Tech Medication Administration for Waivered LPN's
Carroll College	66-68	Clinical Nursing Instructor
St. Peter's Hospital, Helena	61-63	Recovery Room Nurse
Carroll College	57-59	Medical Surgical Nursing Instructor
EENT Group, Helena	56-57	Office Nurse
Veteran's Hospital, Helena	56-61	Staff Nurse

Memberships:

Montana Nursing Association

Publications:

Related Activities or Experience:

RESUME

Personal:

Name: Charles D. Hundley

Address: 216 N. Ewing #3
Helena, Montana 59601

Phone: (Home) (406) 443-1717 (Office) (406) 443-4020

Education:

Institution	Dates	Degree (Major)
MacMurray College Jacksonville, Illinois	1963-1967	B. A. History
Montana State University Bozeman, Montana	1967-1969	M.Ed. - Guidance Counseling, Health and Physical Education
University of Utah Salt Lake City, Utah	1969-1971	Ph.D. - Health Education

Professional Experience:

Place	Dates	Description of Responsibilities
Montana Foundation for Medical Care	8/78-Present	Executive Director Chief Executive Officer for Foundation Programs including Professional Standards Review Organization (PSRO), Peer Review, Indian Health Service, and Consumer Health Education.
Wichita State University Wichita, Kansas	7/74-7/78	Chairperson, Department of Community Health Education and Director, Center for Continuing Health Education, (Learned) [illegible] to Continuing Education for Health Professionals and coordinate Outreach Programs for College of Health Related Professions, graduate and undergraduate teaching responsibilities.

Professional Experience, Cont'd)

Place	Dates	Description of Responsibilitie
University of Arkansas Fayetteville, Arkansas	7/72-7/74	Coordinator - Health Education Programs Curriculum development in health education, graduate and undergraduate teaching responsibilities.
University of Utah Medical Center Salt Lake City, Utah	6/71-6/72	Coordinator, Center for Continuing Health Education. Coordinator of Continuing Education Programs for Health Professionals in six intermountain Veterans' Administration Hospitals.

Memberships:

Present and Past Affiliations

American Society of Allied Health Professionals
American Public Health Association
Association for Continuing Higher Education
American School Health Association
American Alliance for Health, Physical Education and Recreation
American Association of Professional Standards Review Organizations
Various State Health Related Organizations

Publications:

Various Publications in State and National Journals

Other Related Experience

Private Consultant
[illegible] U.S. [illegible] Medical Service Corps [illegible] Pacific
1975.

NAME: John W. McMahon, M.D.

ADDRESS: 6362 Highway 12 West, Helena, Montana 59601

BIRTH: April 28, 1931 - Helena, Montana

FAMILY STATUS: Married, ten children, six foster children

EDUCATION: Elementary and Secondary Education, Butte, Montana, graduated 1949.

University of Santa Clara, received pre-medical training. Graduated with B.S. in Biology as Valedictorian of graduating class, 1953.

St. Louis University School of Medicine, graduated with M.D. degree, 1957.

St. Louis University Group Hospitals, surgical internship and residency completed 1962.

ASSOCIATION MEMBERSHIPS:
American Medical Association
Montana Medical Association
American College of Surgeons
Montana-Wyoming Chapter of American College of Surgeons
Lewis and Clark County Medical Society
Montana Foundation for Medical Care

PROFESSIONAL EXPERIENCE:

MONTANA FOUNDATION FOR MEDICAL CARE: I was instrumental in the establishment of the Montana Foundation for Medical Care in 1972 and served as a member of that organization's Board of Directors since its inception. I was president of the Foundation during its most active period of growth and development in 1975-76 and currently serve as its Medical Director. My responsibilities include, but are not limited to execution of policy and directives of the Board of Directors, advisor and supervisor to all department managers as their work relates to medical activities, advisor and consultant to all Peer Review committees and physician advisors, liason on behalf of the Board with consumer groups, medical and non-medical

MONTANA MEDICAL ASSOCIATION: I have long been active in the Montana Medical Association, and served as chairman or member of numerous standing and special committees of that body, including public relations, legislation, professional liability, legal affairs, publications, emergency medical services, intergovernmental and state, federal relations, and various reference committees of the MMA House of Delegates.

JOINT MEDICAL-LEGAL PANEL - MONTANA MEDICAL ASSOCIATION AND STATE BAR OF MONTANA: I served as member of the committee which developed and implemented the model joint medical-legal panel of the Montana Medical Association and the State Bar of Montana and served as western district panel chairman from 1970 to 1973.

MONTANA HEALTH SYSTEMS AGENCY: I served on the special committee which implemented the Montana Health Systems Agency and was a member of that body's Board of Directors.

AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE AND AMERICAN ASSOCIATION OF PROFESSIONAL STANDARDS REVIEW ORGANIZATION: At the national level, I served as a delegate to the American Association of Foundations for Medical Care and the American Association of Professional Standards Review Organizations. I served as co-chairman of the Public Policy Committee of these organizations and presented testimony in their behalf before congressional committees.

COMMUNITY AWARD:

In 1977, I was an honored recipient of the Carroll College community appreciation award as one of the organizers of the Carroll College student health service, plus other community activities.

SECTION 7.5

RESUMES & CLASSIFICATION SPECIFICATIONS

Jane Anderson
605 East Front
Anaconda, MT 59711
406-563-2861

Birthdate - July 21, 1932
Social Security No. 516-34-9565
Health - Excellent
Birthplace - Anaconda, MT.

Marital Status - Widow
Children - William 1/15/52
Gerard 7/9/55
Margaret 5/22/57

Experience:

1969-1971 - Administered SOS Program - Mt. Powell Economic Council - Responsible for planning and implementation of Emergency Food and Medical Program in a four county area.

1971-1973 Initiated and administered all Senior Projects, Deer Lodge County, MT. Responsible for procurement of Federal funds for establishment of comprehensive Service System for 5,000 elderly in Deer Lodge County MT. Planned with and for elderly persons in Deer Lodge County.

1974-1980 Administrator, Area V Agency on Aging. Responsible for comprehensive program planning, funding and delivery of services for elderly persons in a Six County Planning and Service Area.

Gary Blewett

EDUCATION

B.A., English Literature, Rocky Mountain College, 1960

M.A., English Literature, University of Illinois, 1968

PROFESSIONAL EXPERIENCE

Montana State Department of Social and Rehabilitation Services, 1978 - Present

Position: Administrative Officer, Medical Assistance Budget and Nursing Home Reimbursement Policy

Responsible for preparing the biennial medical services budget, presentations to legislative committees, and monitoring expenditures. Responsible for policy in nursing home reimbursement and other institutional services with cost related basis for rate determination.

Montana State Department of Health and Environmental Sciences, 1975 - 1978

Position: Administrative Officer, Maternal and Child Health Services Budget and Personnel Administration

Administered the non-medical aspects of Bureau operations, including preparation of annual operating budgets, controlling expenditures within budget limits, supervision of administrative performance of Bureau employees, and development and management of performance information systems.

Urban Management Consultants of San Francisco, Inc, 1973 - 1975

Position: Manager of Helena Office and Field Consultant

Managed several consulting contracts serving social service programs and local governments in the mountain plains. Conducted research in Indian demographics, Indian eligibility for economic assistance, approaches to nursing home reviews. Prepared applications for grants in community development programs.

City of Helena, Montana,
1969 - 1973

Position: Evaluation and Budget Director, and Model City Program Evaluator

Directed the operational evaluation system for the Helena Model City Program. Directed the preparation of the annual city budget. Established and maintained a financial planning and control system for the Helena Urban Renewal program.

RESUME

Judith H. Carlson
1823 Flowerree St.
Helena, Montana 59601
406-442-9554

Birthdate: April 2, 1928
Social Security Number: 494-28-3255
Health: Excellent
Birthplace: Springfield, Illinois

Husband: Jack R. Carlson
Chilren: Michael, 7/30/58
Daniel, 10/31/59
Thomas, 7/25/61

Education:

East Denver High School, 1945
Denver, Colorado

Oberlin College, B.A., 1949
Oberlin, Ohio

Washington University, 1949-50
George Warren Brown School of Social Work
St. Louis, Missouri

University of Minnesota, MSW, 1952
Minneapolis, Minnesota

Experience:

10/15/78 to present:

Deputy Director, Department of Social and Rehabilitation Services, State of Montana. Responsible for policy and program coordination between departmental programs, including social services, aging, youth development, assistance payments, medicaid, food & nutrition, vocational rehabilitation, visual services, developmental disabilities. Responsible for federal/state relations on departmental programs. Responsible for staff development. Represents the Department Director as requested.

1/1/77 to 10/15/78:

Special Assistant, Office of Governor - liaision for Governor for human services and Departments of Social and Rehabilitation Services, Health and Environmental Sciences, Labor and Industry, Community Affairs, and Education.

4/23/76 to 12/31/76:

Director, Department of Community Affairs. Under the policy direction of the Governor, full responsibility

4/23/76 to 12/31/76:(cont.)

for administration of the Department, including the divisions of aeronautics, economic development, highway traffic safety, housing, human resources, local government services, planning, research and information systems. Also responsible for the Coal Board, the Office of Indian Affairs, and the liaison with the Old West Commission. Direct preparation of legislative programs and budgets. Serve on the Governor's Cabinet and effect interdepartmental coordination.

9/1/75 to 4/23/76:

Administrative Aide, Office of the Governor of Montana. Reported directly to the Governor. Tasks included those primarily in the area of human resources programs. In the absence of the Governor, chaired the Executive Cabinet for Human Resources. Reviewed policies and made recommendations to the Governor. Handled coores-pondence and inquiries. Represented the Governor on appropriate committees and Boards. Assisted in writing and, on occasion, delivering speeches. Served as a member of the Governor's Forum panels in numerous Montana communities.

August, 1973 to 8/31/75:

State of Montana, Governor's Office - State/Regional Coordinator. Tasks included representing the Governor with the Federal Regional Council in Denver, the Rocky Mt. Federation of Rocky Mt. States, and all regional federal offices; worked on problems between state and federal governments; planned for and wrote grant proposals, specifically where involving more than one state department; provided information to state and local governments on federal programs and policies.

October, 1969 to June, 1973:

City of Helena - Model City Director. Tasks included full responsibility and direction of the Model City program; directed staff of 15-20 and multi-million dollar budget; planning, program implementaion, and evaluation; contracting; worked directly with numerous citizen groups; made recommendations to elected City Commission; developed programs in health, economic development, housing, recreation, social services, captial improvements, community development and urban renewal.

September, 1965 to October, 1969:

Rocky Mountain Development Council, Inc. - Helena, Montana - Executive Director. Tasks included full

September, 1965 to October, 1969: (cont.)

responsibility and director of the Community Action Program (OEO) from initial formation. Built program from zero to a staff of over 100 and a multi-million dollar budget. Initiated Neighborhood Youth Corps, Head Start, On-the-Job Training, Operation Mainstream, Senior Citizens Center, Foster Grandparents, Daily Dinner Club; build relationships and coordinated activities with wide range of community agencies, state and federal government agencies; wrote grant proposals; reported to Board of Directors of 18 members.

1958 - September, 1965:

No regular employment while the children were young. For two of these years, I did private marriage counselling in Great Falls; member, Americal Association of Marriage and Family Counsellors, Active in League of Women Voters and Church Activities, serving in leadership positions.

July, 1957 - June, 1958:

Powell, Deer Lodge, and Granite Counties - Child Welfare Worker.

June, 1956 - July, 1957:

Yellowstone County - Casework Supervisor.

June, 1953 - June, 1956:

Ramsey County, Minnesota - Child Welfare Worker.

June, 1951 - June, 1953:

Family Service Agency of St. Paul (Minnesota) -Family Caseworker.

June, 1950 - June, 1951:

State of Missouri, Cape Girardeau County - Child Welfare Worker.

Parttime and summer experience: camp counselor, waitress, maid, resident counsellor in treatment center for disturbed children.

Other Activities:

1964-68, Member, Board of Directors, Montana League of Women Voters

1964-65, 1st woman member, Vestry, Church of Incarnation, Great Falls

1968-69, Chairperson, Helena Community Council

1971-73, Member, Executive Council, Episcopal Diocese of Montana

1973-76, Member, Vestry, St. Peter's Cathedral, Helena

1974-Present, Member, Casey Family Program Advisory Committee; Chairperson, 1976-77

1977-80, Member, Oberlin College Alumni Association Board

1980, Senior Warden, St. Peter's Catherdral, Helena

RESUME

John DeVore
229 Keith Avenue
Missoula, Montana 59801

Married
Two Children
Age: 36

EDUCATION

Arizona State University - Graduated 1972
Degree: B.S. Political Science
Minor: Sociology
Undergraduate Work: 15 hours in Accounting and Business Administration

PROFESSIONAL EXPERIENCE

Missoula County, Courthouse Annex, Missoula, Montana 59801

Present Position - 10/13/79 to present

Grants Coordinator - Overall responsibility to provide staff assistance to the Missoula County Commissioners and Department Heads in the area of Grants Development, Monitoring, and Coordination. Primary responsibilities for development and initiation of liasion with various State and Federal agencies and the Congressional delegates, as well as technical assistance to various County Departments and Community Based Organizations in the areas of grant development, planning, and management capability. Position is also responsible for the development and implementation of a County Economic Development Plan, Capital Improvement Plan, County Comprehensive Aging Services Plan, and General County Services Plan. Position has secondary responsibilities for the provision of staff assistance to the Missoula County Council on Aging in the areas of grants development, planning, contracting for services, monitoring, and evaluation.

Northern Arizona Council of Governments

Previous Position - 2/23/77 to 10/05/79

Chief, Human Resource Division - Overall responsibility for CSA planning and program implementation including Local Initiative, Weatherization, Crisis Intervention, Community Food & Nutrition, Senior Opportunity and Services, Rural Home Repair, and Special Projects. Primary responsibilities for Title XX Planning and implementation, Aging Planning, Energy Planning, with administrative responsibilities for Senior Citizens Programming including nutrition, transportation, facility development, outreach, information and referral, homemaker, employment, training, and program development, as well as RSVP implementation. Position is also responsible for development of activities in appropriate technology, specifically construction and operation of a Community Solar Greenhouse and statewide workshops.

Previous Position - 10/25/76 to 2/22/77

Senior Human Resource Planner - Responsible for general planning in Human Resources for the Agency, with primary responsibilities in Title XX planning and implmentation, CSA planning and implementation, with responsibilities for development of a regionwide legal aid service, low income plan and transportation. Also responsible for development and implementation of a statewide T/TA contract, funded through Title VII OAA funds.

Previous Position - 8/23/76 to 10/25/76

Acting Director Headstart - Responsible for resolving management problems within the NACOG/Headstart Program, with primary responsibility in resolving funding problems. Completion of the assignment involved the following: Approval full year/part day grant, approval handicapped grant, approval of expenditure of $9,300 COB funds, and development and approval of grant application for new program year.

Previous Position - 10/01/75 to 8/23/76

Assistant Director Area Agency on Aging - Responsible for development and administration of regionwide Title VII Nutrition projects, Title III programming, Title IX, Regional CSA Mini-Grant Programs for the elderly, Title XX Information and Referral and Nutritional supplementation, and regionwide transportation services. Responsible for program development with various senior citizens groups and local units of government. Preparation of Area Agency Plans, proposal writing on the State and Federal level, participation in Title XX planning process, development of grants management process for administration of Title VII and CSA mini-grants. Conducting local workshops with senior groups identifying roles and responsibilities.

All the above positions have demanded extensive fiscal management, with budgets ranging from $100,000 to $2,500,000 annually.

Native Americans for Community Action

Length of employment - 9/74 to 10/1/75

Position: Administrative Assistant - Responsible for development of accounting systems for fiscal management of all grant funds, including preparation of monthly, quarterly and annual reports to Federal and State agencies. Responsible for adherance to Grant Regulations; researching new sources of funding; developing new programs; proposal writing on State and Federal level; conducting local fund raising events; and public relations work, developing good working relations between our agency and the community.

Great Western Bank & Trust

Length of employment - 9/72 - 9/74

Position when hired: Collector - Master Charge Department

Position when leaving: Manager Master Charge Merchant Division, Responsible for Merchant Program, both solicitation of merchants and operations. Oversee day to day operations; preparation of daily and monthly reports; assign and review all workloads; prepare the reviews and interviews; traveling across United States selling program; conducting merchant education programs; preparing cost controls; and conducting indepth investigations of potential customers.

Other Training:

January 1976 - Oregon State University
40-hour training session on Administration of Title VII OAA programs.

August 1976 - Community Nutrition Institute, Washington D. C.
40-hour training session on program development and management

November 1978 - Civil Service Commission
20 hours mid-level management

February 1980 - Municipal Finance Officers Association
20 hours - Indirect Cost Development

Funded Proposals

Native American Survey - Title II - CSA
Indian Alcoholism Project - NIAAA
Technical Assistance Project for Reservation Communities - Title I HEA
Summer Youth Program - Title I - CETA
Native American Community Center - ONAP
Senior Citizens Center - Bicentennial Commission
Winslow Title VII Project - Title VII - OAA
Prescott Title VII Project - Title VII - OAA
Flagstaff Title VII Project - Title VII - OAA
Regional Aging Plan - Title III - OAA
Regional Information and Referral - Title XX - SSA
Nutritional Supplementation - Title XX - SSA
Citizen Participation (special project)
Four Corners Regional Commission
Regional Headstart Plan - OCD
Training and Technical Assistance Program - Headstart - OCD
Statewide Technical Assistance Project - Title VII - OAA
Community Food & Nutrition - CSA
Solar Energy Project for Prescott
VISTA
Department of Energy - Appropriate Technology
National Science Foundation
CSA Unsolicited Project - Housing
Courthouse Rennovation - National Historic Trust
Rural Home Repair Project - CSA
Technical Assistance Project - Housing Assistance Council

Consulting Services

ACKCO INC.
2017 10th St.
Boulder, Colorado 80302

WASSKA
Technical Systems & Research Co.
6035 University Ave. Suite 22
San Diego, CA

Tribal American Consulting Corp.
T/TAP Project
8060 E. Florence Ave., Suite 308
Downey, CA 90241

Present Memberships

Board Member - District II Human Resource Council
Board Member - Bitterroot RC & D
Member - National Association of Housing and Redevelopment Officials
Member - Western Gerontological Society
Member - National Council on Aging
Member - National Association of Counties

Past Memberships

Community Representative - Association of Arizona Indian Center
Member-Advisory Board - NAU Sociology Planning Program
Member-Governors Board - Arizona Solar Action Team
Member - Arizona Community Action Association

References provided upon request.

RESUME

Jack Dorner
1519 Walnut Street
Helena, Montana 59601

Birthdate: August 9, 1923

Social Security #: 516-20-8689

Health: Good

Birthplace: Helena, Montana

Education: Helena High School, 1942
Helena, Montana

Montana State University, 1946-1947
Missoula, Montana

Carroll College - B.A., 1947-1950
Helena, Montana

San Diego State University - M.S.W., 1968-1970
San Diego, California

Experience: June, 1977 - to present
Montana Social and Rehabilitation Services,
Program Manager IV
Medicaid Program liaison for Pre-admission Screening, Discharge and Alternate Care Program with Social Services and PSRO. Responsibilities also include special nursing home problems and liaison with Developmental Disabilities Program. Member of Inter-Agency Task on Long-Term Care Alternatives.

January, 1972 - June, 1977
Montana Social and Rehabilitation Services,
Medical Care Specialist
Responsibilities included performing utilization and medical review of nursing homes, on-site, with R.N..

June, 1970 - December, 1971
Lewis and Clark County Welfare Department,
Social Service Supervisor,
Adult Services.

September, 1968 - June, 1970
Attended San Diego State,
Field placements included Adult Services,
San Diego County Welfare and Community Mental
Health Services.

June, 1967 - September, 1968
Glacier County Department of Welfare,
Blackfeet Indian Reservation -
Social Worker. Case management for caseload
of child and adult services.

DAVID A. FEFFER
103 IRONWOOD PLACE
MISSOULA, MONTANA 59801

EDUCATION

- Bachelor of Arts, major in History and International Studies, University of North Carolina, 1971.
- Master of Public Health, University of North Carolina, 1975.
- Languages: working knowledge of French and Spanish.

SKILLS

- Organizational Management - goal setting, program planning, finance, marketing, organizational development; Health policy formulation and analysis; Health promotion programming; Health systems planning, organization, research and evaluation; Community organization.

PROFESSIONAL ORGANIZATIONS

- American Public Health Association
- Montana Association of Local Health Officers
- Montana Public Health Association

WORK EXPERIENCE

- 8/77 to Present: Health Officer, Missoula City-County Health Department. Pesponsibilities entail technical and administrative management of Health Department programs -- air and water pollution control, general sanitation, health education, health promotion, maternal and child health, communicable disease control, school health, home health, alcohol, nutrition. Staff of 70.
- 5/75 to 5/77: Director of Welch, West Virginia Field Service Office of the United Mine Workers of America, Health and Retirement Funds. Staff of 17 serving 48,000 beneficiaries of Health and Retirement funds. Beyond administrative responsibilities, concentrated on development of community health clinics, community board development, writing grant proposals, recruitment of health personnel, organization of Community Health Action Council, financial negotiations with health care providers, development of a comprehensive countywide health promotion program; served as Vice Chairman of the Southern West Virginia Health Systems Agency Advisory Countil: and establishment of the Southern West Virginia Primary Care Study Group (precursor of the West Virginia Rural Health Association).
- 10/74 to 5/75: Program evaluation and research with the Lincoln Community Health Center, Durham, North Carolina.

- 5/74 to 7/74: Consultant with the Pan American Health Organization in Columbia, South America. Included research and writing of case study on development and administration of family planning services in Columbia, and the provision of consultation in administration to the Ministry of Health national family planning and maternal and child health program.
- 11/73 to 5/74: Research assistant with the Department of Health Administration, University of North Carolina School of Public Health, Chapel Hill. Studied correlation between national health expenditures and national health status, an international comparative study.
- 11/71 to 5/73: Administrative Officer for the Department of Health and Population Dynamics of the Pan American Health Organization in Washington, DC. Involved preparation and control of program plans and budgets, writing grant proposals, participation in funding negotiations, setting up financial and administrative mechanisms for program implementation, administrative consultation to country program managers, and preparation of contracts and country agreements.

PUBLICATIONS AND PAPERS PRESENTED

- Feffer, D.A.; "A Case Study on the Administration of Family Planning Services in Columbia, South America," July, 1974. Study used as teaching aid for Latin American family planning administrators.
- Hand, J, Feffer D.A.; "A Successful School Immunization Program...or Not?" Journal of School Health, January, 1980.
- Poetry published in: "Sumus Review" and in "Paint Brush Canyon" 1970.
- "Filling the Health Care Leadership Vacuum" Essential Role for Public Health, APHA, 1979.
- "Methodology and Results of a Local Health Department's Research on Child Health Care" (co-author), APHA, 1979.
- "Missoula Gradeschool Immunization Initiative" (co-author) APHA, 1979.

COMMUNITY ACTIVITIES

- Western Montana Health Education Council, Board of Directors.
- Missoula Planned Parenthood, Board of Directors, Executive Committee.
- Five Valleys Health Care, Inc., Board of Directors 1977-1979.
- Area Coordinator for Health Activation Network.

PERSONAL DATA

- Date of Birth: November 22, 1948.
- Married
- Leisure interests: Poetry, classical guitar, soccer, hiking, cross-country skiing, reading, travel.

HOLLY LUCK

Present Address

601 S. Montana Ave.
Helena, Montana 59601
(406) 443-3576

Work Address

State of Montana
Department of SRS
Aging Services Bureau
Box 4210
Helena, Montana 59601
(406) 449-5650

Professional Objective: To guarantee quality services for the senior citizens of Montana as Chief of the SRS/Aging Services Bureau.

Education: Bachelor of Arts, Carroll College, May, 1971
MAJOR: Sociology/Social Work with special emphasis on the elderly.

Work Experience: 1978-Present: Chief of the SRS/Aging Services Bureau. Administer a $4 million dollar (federal/state) statewide senior citizen program.

1974-78: Director, Area IV Agency on Aging. Administered a 6 county senior citizen program funded under Title III of the Older Americans Act.

1971-74: Asst. Director Foster Grandparent Program. Supervised 60 elderly workers at the Boulder River School and Hospital and Eastmont Training Center, Glendive, Montana.

Professional Organizations: National Association of State Units on Aging
Western Gerontological Society
Montana Senior Citizens Association
Montana Task Force on Advocacy for Seniors

Background and Interests: Native of Montana and educated in Montana schools. Interested in travel, outdoor activities and working with people.

Professional Accomplishments: 1979-80: Organized and lead the planning effort to establish Montana's first Legacy Legislature. A mock session of the legislature seating 63 elderly legislators who will be responsible for planning, developing and passing legislation of concern to all Montana elderly.

State Coordinator for the 1981 Montana White House Conference on Aging.

Personal Resume'
Holly Luck
6/80

1974-79: Organized three (3) elderly nutrition programs in Park, Gallatin and Meagher Counties providing nutrition service, transportation, escort services, social and recreational activities for approximately 250 elderly.

Established a home health/homemaker service for the residents of Lewis and Clark, Jefferson, Broadwater, Gallatin and Park Counties (with special emphasis on services to the elderly).

Established new senior citizens centers/programs in Lincoln, Augusta, Whitehall, East Helena, Boulder and Wilsall, Montana. Services indluded: information and referral, transportation, escort, social and recreational activities.

1971-74: Organized and implemented the Foster Grandparent Program at the Eastmont Training Center in Glendive, Montana. Supervised an additional ten (10) elderly workers serving approximately 25 residents.

References: Available upon request.

Norma Vestre
B.D. 8-14-42

Bachelor of Science 1964 Montana State University
Emphasis in Psychology

MSW 1970 University of Utah Graduate School of
Social Work

1964-68 Work Experience
Social Worker - Lewis & Clark County Welfare Department

1970-71 Social Services Supervisor - Helena District

1972-1974 Social Services Consultant - Child Welfare Services Bureau

1974 Chief - Family & Adult Services Bureau

1975 Chief - Social Services Bureau
(3 bureaus consolidated into one)

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

CLASS SPECIFICATIONS

CLASS CODE > 187012
GRADE > 15
LAST UPDATED > 7-1-74

OCCUPATIONAL GROUP: Service Industry Managers and Officials

MONTANA CLASSIFICATION TITLE > Program Manager IV (Program Manager)

DESCRIPTION OF WORK

GENERAL DUTIES: Performs supervisory and complex professional duties in planning, coordinating and directing a specific education or service program for a particular clientele.
SUPERVISION RECEIVED: Works under general guidance and direction of an administrative superior.
SUPERVISION EXERCISED: Exercises supervision over clerical, technical and professional personnel.

EXAMPLE OF DUTIES

Attends areawide meetings and participates in planning committees; prepares legislation; assesses needs and problems of a particular clientele and develops policies, guidelines and goals for a program to fullfill these needs; prepares budgets and maintains effective cost control for program expenditures; trains volunteers and employees; assigns, supervises and evaluates duties of personnel; promotes public awareness of programs through public appearances, news letters and press releases; acts as a consultant to other agencies and programs; develops curriculum and other program material; coordinates activities among other agencies and programs which have same goals; performs related work as required.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Thorough knowledge of techniques of planning and organization; program material development; personnel training and management; working knowledge of problems and needs of group for which program is aimed; some knowledge of public relation techniques.
SKILLS: None
ABILITIES: Ability to plan and direct activities and programs; to train and supervise personnel; to establish and maintain effective working relationships with employees, other agencies and the public.
EDUCATION: Graduation from a college or university with a Master's degree in Education or field related to the particular program.
EXPERIENCE: Two years of experience in program administration and planning,

OR

Any equivalent combination of education and experience.

USER AGENCIES

	All	* As Noted Below	All Except Those Noted Below
	3501 5301 6901 6505		

NOTE: Duties described above are not necessarily all inclusive for this class.

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

CLASS SPECIFICATIONS

CLASS CODE: 195010
GRADE: 13
LAST UPDATED: 7-1-74

OCCUPATIONAL GROUP: Occupations in Social and Welfare Work

MONTANA CLASSIFICATION TITLE: Social Worker III

DESCRIPTION OF WORK

GENERAL DUTIES: Performs advanced professional level social work with individuals experiencing severe mental health behavior or familial problems, or with individuals with severe emotional or physical handicaps.
SUPERVISION RECEIVED: Works under the general guidance and direction of an administrative superior.
SUPERVISION EXERCISED: Supervises personnel as assigned.

EXAMPLE OF DUTIES

Interviews clients and makes collateral contacts in order to assess the nature and severity of clients' problems; provides direct services to individuals experiencing severe or chronic problems in social functioning; may initiate group work involving clients with similar problems; works with social service personnel to identify client needs being met through existing community resources; works with appropriate community groups and organizations to develop an awareness of unmet client needs; works with these groups to identify and promote the development of needed resources; promotes the continuation and improvement of newly developed resources; serves as a technical consultant on difficult cases; prepares and maintains case records, correspondence and reports; processes referrals to related public and private agencies; performs related work as required.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Thorough knowledge of social problems, illnesses and disabilities. Considerable knowledge of the principles and techniques of social casework, community organization and development.
SKILLS: None.
ABILITIES: Ability to diagnose severe problems in social functioning; to develop and implement treatment plans with individuals experiencing severe problems in social functioning; to identify client needs not being met through existing community resources; to mobilize community groups and organizations in the development of resources; to evaluate objectively the success or failure of plans of intervention.
EDUCATION: Graduation from a college or university with a Bachelor's degree in the social sciences or a related field.

OR

Any equivalent combination of education and experience.

USE AGEN

NOTE: Duties described above are not necessarily all inclusive for this class.

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

CLASS SPECIFICATIONS

CLASS CODE	075002
GRADE	13
LAST UPDATED	3-14-75

OCCUPATIONAL GROUP: Registered Nurses

MONTANA CLASSIFICATION TITLE: Nurse, Professional II

DESCRIPTION OF WORK

GENERAL DUTIES: Performs professional nursing duties of average difficulty in a clinic, institution or a public health agency.
SUPERVISION RECEIVED: Works under general supervision of an administrative superior.
SUPERVISION EXERCISED: Exercises supervision over subordinate health care personnel.

EXAMPLE OF DUTIES

Assists physician with diagnostic procedures and treatment regimens; gives immunizations, treatments and medications under the physician's orders; assigns and supervises duties of hospital or clinic personnel; maintains continuity of patient care by coordinating work with other health professionals and social agencies; promotes and maintains health of individuals, families and the community through teaching, counseling and appropriate preventive and rehabilitive measures; assists in developing nursing care plans; maintains and interprets standards of public health nursing to committees, other health organizations and community groups; assists in training personnel; performs related work as required.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Considerable knowledge of patient care or public health nursing principles and concepts; terminology, equipment, techniques and practices; dynamics or interpersonal relationships; human growth and development; available community resources.
SPECIAL SKILLS: Skill in the use of nursing treatment and diagnostic instruments and equipment.
ABILITIES: Ability to react in emergency situations; to use good judgment; to work effectively with others; to follow directions; to assume responsibility for professional growth and development; to communicate effectively verbally and in writing.
EDUCATION: Graduaton from an accredited school of Professional Nursing.
EXPERIENCE: One year professional nursing experience.

OR

Any equivalent combination of education and experience.

NECESSARY SPECIAL REQUIREMENTS

USER AGENCI: 5113 5301 6401 6402 6403 6409 6410

NOTE: Duties described above are not necessarily all inclusive for this class.

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

CLASS SPECIFICATIONS

CLASS CODE	201002
GRADE	8
LAST UPDATED	3-14-75

OCCUPATIONAL GROUP: Secretaries

MONTANA CLASSIFICATION TITLE: Secretary II

DESCRIPTION OF WORK

GENERAL DUTIES: Performs a variety of secretarial and clerical duties of average difficulty for the head of an organizational unit or board.
SUPERVISION RECEIVED: Works under general supervision of an administrative superior.
SUPERVISION EXERCISED: Exercises supervision of clerical personnel as assigned.
DISTINGUISHING CHARACTERISTICS: This class differs from lower level secretaries by the number and/or class of personnel supervised and/or difficulty and importance of duties and responsibilities as found in more complex composition of correspondence, more important public contact and/or confidential nature of the work performed.

EXAMPLE OF DUTIES

Types correspondence, reports, and a variety of other material; arranges appointments, interviews, and travel schedules for supervisor; reads and routes mail; composes correspondence and answers general inquiries and questions; performs primary screening of callers and visitors; maintains files and prepares bookkeeping, payroll, and other records and reports; maintains budget for supplies and services; handles clerical details of projects and events supervisor; may take and transcribe dictation; may supervise duties of clerical personnel; performs related work as required.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Working knowledge of office practices and procedures; business English, composition, and bookkeeping.
SPECIAL SKILLS: Skill in the use of office equipment.
ABILITIES: Ability to compose correspondence; to establish and maintain effective working relationships with employees, other agencies, and the public; to communicate effectively verbally and in writing; to handle clerical details of office projects and events.
EDUCATION: One year of secretarial coursework at a college or technical school.
EXPERIENCE: Two years of experience in general office and secretarial work.

OR

Any equivalent combination of education and experience.

USER AGENCIES: [ ] All [*] As Noted Below [ ] All Except Those Noted Below

3101 3102 3103 3105 3401 3501 4102 4103 5103 5104 5105 5106 5107 5108 5109 5110 5119 5201

NOTE: Duties described above are not necessarily all inclusive for this class.

STATE OF MONTANA
DEPARTMENT OF ADMINISTRATION
PERSONNEL DIVISION

CLASS SPECIFICATIONS

CLASS CODE: 195001
GRADE: 8
LAST UPDATED: 7-1-74

OCCUPATIONAL GROUP: Occupations in Social and Welfare Work

MONTANA CLASSIFICATION TITLE: Eligibility Technician (Screener)

DESCRIPTION OF WORK

GENERAL DUTIES: Performs technical social assistance work in determining clinets' financial eligibility for social assistance programs.
SUPERVISION RECEIVED: Works under close supervision of an administrative superior.
SUPERVISION EXERCISED: None

EXAMPLE OF DUTIES

Determines clients' initial and continual financial eligibility for such programs as: general assistance, aid to dependent children, aid to the needy blind, aid to the permanently and totally disabled, medical assistance, food stamps and other assigned programs; determines financial eligibility through interviewing clients and interpreting policies, rules, regulations and objectives of the department; prepares and maintains case records, dictates case findings and correspondence and prepares necessary forms and reports as they relate to financial eligibility; assists applicants or recipients to make use of all resources related to financial assistance; refers applicants or recipients who appear to be in need of protective services or social services to appropriate social work staff; performs related work as assigned.

MINIMUM QUALIFICATIONS

KNOWLEDGES: Some knowledge of social and economic conditions in the community; individual problems that result in dependency; background and principles of federal and state legislation pertaining to public assistance; resources relating to financial assistance; business English, spelling and arithmetic.
SKILLS: None.
ABILITIES: Ability to establish and maintain effective working relationships with employees and the public; to follow written and verbal instructions; to communicate effectively verbally and in writing.
EDUCATION: High school graduation.
EXPERIENCE: One year of experience in work which involves meeting or providing service to the public.

OR

Any equivalent combination of education and experience.

USER AGENCIES: All | * As Noted Below | All Except Those Noted Below

6901

NOTE: Duties described above are not necessarily all inclusive for this class.

APPENDIX A

DESCRIPTION OF STATE AGENCIES WHICH SUPPORTS LONG-TERM CARE

APPENDIX A

A-1 The Department of Social and Rehabilitation Services - This Department is the focal point of programs for the elderly in Montana. It includes the Aging Services Bureau, Social Service Bureau, Medical Assistance Bureau, Visual Services Division, Developmental Disabilities Division, Food and Nutrition Services Bureau and Veterans Affairs Program.

A-1-1 Aging Services Bureau - This Bureau is the overall planner, coordinator and evaluator of all Federal and State funded programs designed to serve the elderly of Montana. By regulation, the only direct service that this State agency can provide is information and referral. Consequently, the primary role of the Aging Services Bureau is that of advocacy and State-level administrator of programs funded for the elderly. The Bureau distributes State and Federal funds, evaluates and assesses programs, provides technical assistance and training for a statewide system of Area Agencies and service providers that deal directly with the older citizens of Montana.

Area Agencies on Aging - There are seven Area Agencies on Aging in Montana. These Area Agencies are "grass roots" administrators of programs and services for Seniors. They are charged with the continuing process of planning services for older persons at the local level, coordinating the actual delivery of needed services, full utilization of existing services and resources, and the development of new or additional resources.

The key to Information/Referral and Outreach for Senior Citizens in Montana is a toll-free incoming only telephone to the Governor's office through his Citizen Advocate. The Citizen Advocate transfers all calls from or dealing with, persons 55 and over on a direct trunkline to the Aging Services Bureau. Each area agency has an adequate number of Referral Technicians to make personal contact on follow-up of any persons who utilize the Information and Referral network.

A Nursing Home Ombudsperson Project establishes a statewide network in cooperation with the existing Information and Referral Technician, to provide contact with all nursing homes and provide grievance procedures to all staff and clients.

Title IV-A Training Grant - Under the Older Americans Act, this project's goal is to improve the quality of services for the aged and to help meet critical shortages of adequately trained personnel for programs in the field of aging. This is accomplished by providing direct training to personnel of the Aging Services Bureau, the Area Agencies and those individuals working directly with aging programs at the local level through a contract with the Montana State University, Department of Gerontology.

Nutrition Program - This program is designed to assist in meeting the nutritional need of those citizens 60 years of age and older. The program provides permanent nutrition projects and the supportive services to insure maximum effectiveness of the meals provided. There are eight (8) individual Title VII Nutrition Projects in the State of Montana. (See Exhibit A-1.)

Legal Services Grant - This project was designed to increase the availability of legal services to the Senior Citizens of Montana. The task is accomplished through a contract with Montana Legal Services Association.

A-1-2

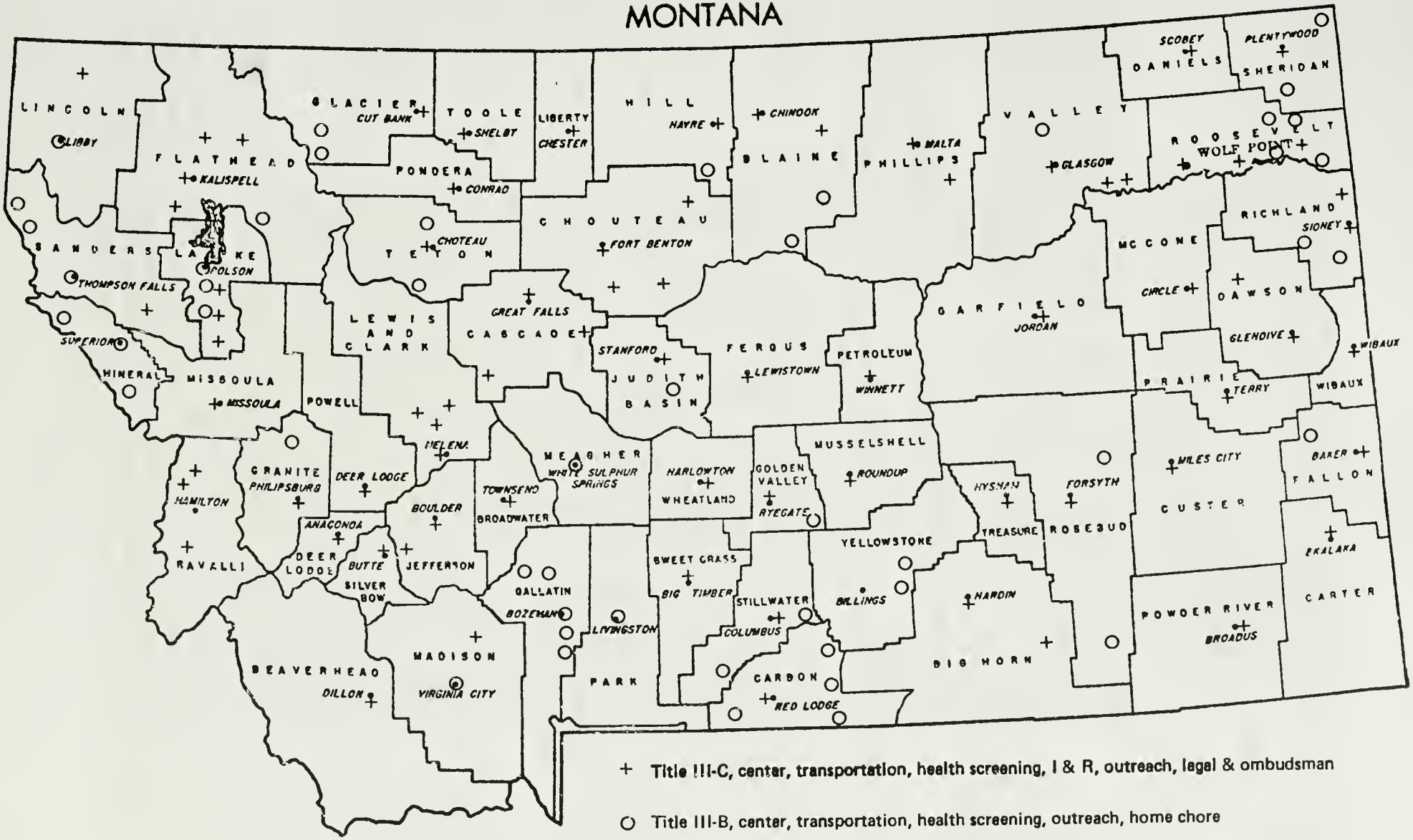
Medical Assistance Bureau - The Medical Assistance Bureau administers the Montana Medicaid (Title XIX program. This program covers the following mandatory benefits with the limitations noted:

Hospital Care - No limits
Physician Services - No limits
Lab and X-Ray Services - No limits
Family Planning - No limits
Skilled Nursing Facility Care - No limits
Home Health Services - Up to 200 visits per fiscal year. Total payment per month may not exceed $400 per paient without prior authorization.
Early Periodic Screening, Diagnosis and Treatment for individuals under 21.

Optional Services include:

Dental services
Drugs - first 2 prescriptions free, 50¢ for each additional prescription
Physical Therapy, Occupational Therapy, Speech Therapy - 200 visits per fiscal year
Intermediate Nursing Facility Care - No limits
Transportation for Medical Care - Prior authorization

MONTANA



+ Title III-C, center, transportation, health screening, I & R, outreach, legal & ombudsman

○ Title III-B, center, transportation, health screening, outreach, home chore

EXHIBIT A-1

Personal - Montana is one of nine states utilizing this service to supplement home health services.
Applicances, artifical limbs, wheelchairs
Podiatry
Mental Health Clinic Services
Hearing Aids and audiology services
Home dialysis support services
Optometric services

Medically Needy Program - Montana is one of 33 states to provide coverage to the medically needy, those individuals who would be eligible for cash assistance except for their income level. Eligibility income level for the Medically Needy program in Montana is 133-1/3% of Aid to Families with Dependent Children payment.

Supplemental Security Income (SSI) Program - In Montana, the Social Security Administration determines eligibility for Medicaid using SSI criteria. (This is known as the "1634" agreement and is less restrictive than the 209 (b) option.)

Pre-Admission Screening Program - In order to expand the scope of community services and to channel appropriate patients into less costly care, the Medical Assistance Bureau, in cooperation with the Social Services Bureau and the Montana Foundation for Medical Care (MFMC) (the designated PSRO in Montana), initiated a pre-admission screening and discharge program for medical assistance applicants/residents of long-term care facilities in July, 1978. Twelve medical social workers were hired to work in conjunction with nurse coordinators and physician advisors of MFMC in an interdisciplinary team approach to pre-admission screening. The funding, through legislative appropriation, was cut back in the January, 1979, legislative session. The program is continuing, but on a limited basis. There are now eight medical social workers and a like number of nurse coordinators throughout the State. The target population includes those residents in hospitals identified by the nurse coordinator as needing alternate care on discharge and persons applying for nursing home admission directly from their own home (Medicaid applicants or eligibiles only).

Nursing Home Reimbursement Program - The Department is currently evaluating several methods of assessing the care requirements of patients in long-term care facilities. It is hoped that a final assessment instrument can be used as the basis for reimbursement of direct care costs; for evaluating the appropriateness of placements; and for determining staff levels for the purpose of licensing and certification.

At the present time, consultants for the department are using a patient assessment instrument developed by Carl Adams of the National Health Corporation to determine patient care requirements in ICF and SNF facilites which have requested a review of the adequacy of their reimbursement rates. Also, the Montana Foundation for Medical Care is testing a more refined instrument developed by the State of Ohio as part of the evaluation of the ability of such instruments to accurately predict care requirements of patients in long-term care facilities.

An advisory committee has been formed for the purpose of provider and consumer input in developing equitable reimbursement rules. Membership of this committee includes representatives from nursing home providers, legislators, nursing home ombudsperson, Health Department, Montana Foundation for Medical Care and Medicaid.

A-1-3 Social Services Bureau - The Social Service Bureau administers the Title XX program. This program covers the following services:

Adult Foster Care - This program promotes and secures foster care in foster and group homes. These services are available to persons age 18 and over who are unable to remain in independent living situations. Also included are persons in institutions who need community placement by providing counseling services to adults upon the initiation or termination of placement. An evaluation assessment of client needs is provided by a process of counseling, recruiting, evaluating and licensing adult foster homes and community homes for the developmentally disabled.

Health Related Services - This program provides services to assist adults in order to attain and remain in optimum condition of health by assisting in the utilization of necessary medical treatment services. Services of this program include helping people to understand their illnesses, arranging for transportation to and from medical services, working with individuals and family members to assure that medical recommendations are followed, and working with medical practitioners to assure that appropriate services are provided.

Home Attendant Services - Homemaker services include assistance and demonstration in meal planning, preparation and food buying, assistance with doctor and dental appointments, shopping for household items and clothing, clothing repair, light household chores and child management.

Informational, Referral, Follow-up Services - This service provides information to any person, on request, regarding Title XX and related programs. Where appropriate, referrals are provided to Title XX and other program resources and follow-up are provided to assure the provision of services requested.

Institutional Placement and Counseling - This program arranges appropriate institutional placement for individuals to nursing homes, boarding homes and personal care homes. Activities include pre-admission screening, monitoring and counseling after placement. In addition to the placement function, this program develops community placement and community care alternatives for persons presently residing in nursing homes. All eligible medical components will be paid for with Title XX funds.

Protective Services for Adults - Protective Services are services directed at the goal of preventing or remedying neglect, abuse or exploitation of adults over age 18 who are unable to protect their own interest. Activities of this service include identification, investigation and diagnosis, provision of counseling, arrangement of appropriate alternative living arrangements, assistance in locating medical and legal care, including guardianship of person, arrangement of protective placement, and the provision of advocacy.

A-1-4 Developmental Disabilities Bureau - The Developmental Disabilities Bureau serves developmentally disabled individuals by purchase of service contracts including: residental services (community homes, semi-independent training in community apartments), vocational services, transportation, and respite in specific designated residental settings.

A-1-5 Visual Services Division - The Visual Services Division provides vocational rehabilitation services to blind and visually impaired individuals which include the following services:

medical and vocational diagnosis
physical restoration services
training for a job
job placement
follow-up services

The Visual Services Medical Program provides necessary eye care for Montana residents who are determined medically indigent. This program includes surgery, hospitalization and subsequent prosthesis.

A Business Enterprise Program implements the Randolph-Sheppard Act and small businesses for individuals. A Mobility and Orientation Program trains blind individuals to travel independently in support of their vocational rehabilitation. The Rehabilitation Teaching Program trains individuals in daily living skills to operate and function in their own homes, and trains hospital and nursing home personnel techniques for working with blind and visually handicapped patients.

A-1-6 Food & Nutrition Bureau - This Bureau admiisters the Food Stamp Program in Montana. At the current time, there are approximately 17,000 households (48,000 individuals) being services by this program.

A-1-7 Veteran's Affairs Program - The primary function of the Veteran's Affairs Division is to ensure that the veterans and their dependents receive assistance in filing claims for any and all benefits they may be entitled to through the Veteran's Administration. Total budget comes from State General Fund.

A-2 Department of Institutions - This department is responsible for supervision of the ten Montana institutions, 5 of which are involved with services to the elderly.

Montana Veterans Home - Nursing Home - Columbia Falls, MT, serves 123 elderly veterans.

Montana Center for the Aged - Lewistown, Mt. A 199 bed skilled and intermediate Nursing Home serving the elderly-psychiatric.

Warm Springs State Hospital, Warm Springs, Mt. serves a mixed age group of 323 persons.

Boulder River School and Hospital, Boulder, MT, a 242 intermediate nursing bed facility serving the severely developmentally disabled (mixed age group).

Galen State Hospital - A 185 bed intermediate care facility serving chronic medical and alcoholic (nixed age group).

Montana Mental Health Centers - Montana's five Mental Health Centers located in Billings, Missoula, Great Falls, Glendive, and Helena are independent institutions providing direct service to those people needing assistance for emotional problems.

A-3 Department of Community Affairs

A-3-1 Community Services Division - As the State Community Action Agency, the division funds, monitors and evaluates the activities of the State's ten (10) Human Resource Development Councils. These agencies are local organizations implementing the State's anti-poverty programs which assist the low-income, handicapped and elderly persons with home winterization, employment assistance and training, and community food and nutrition projects. Included are supplemental elderly feeding programs covering a twelve district area. This agency mobilizes and coordinates anti-poverty resources, provides the Governor with information and advice with respect to the policies and programs of Federal anti-poverty programs, prepares a three year anti-poverty plan for the State and provides an annual written analysis of the problem of poverty within Montana.

A-3-2 Indian Affairs Unit - This office is responsible for assessing the problems of all Montana Indian people, to communicate their opinions and needs to appropriate agencies, to assist in organizing their efforts and to act as representatives and spokesman for Indian organizations as requested.

A-3-3 Planning Division - This division administers a Federal Grant program which provides capital assistance to private, non-profit organizations for elderly transportation. A number of senior citizen centers and county councils on aging have purchased vans through this progarm.

A-4 Department of Health and Environmental Sciences (DHES) -

A-4-1 Medical Facilities Bureau - This bureau is responsible for State licensure of medical facilities in Montana. The Bureau also determines compliance with Federal conditions and standards of nursing home providers of Title XIX services through contract with Montana Social and Rehabilitation Services.

A-4-2 Health Planning and Resource Development Bureau (SHPDA) - This bureau works directly with Montana Health Systems Agency (HSA) in planning for a comprehensive system of long-term care supports. The Bureau is also the lead Bureau of DHES involved in the study conducted by JRB Associates to analyze the current status of long-term care in Montana. (This study is discussed in detail in Section 3.11.2.)

A-5 Department of Labor -

A-5-1 Human Rights Division - Established by the Legislature in 1974, this agency investigates complaints of discrimination and is the administering agency for the Montana Human Rights Act, Code of Fair Practices and by contract, Title VII of the Federal Civil Rights Act of 1964.

A-6 State Board of Education -

A-6-1 Montana Center of Gerontology - The Center, designated by the Board of Regents of the Montana University System on April 9, 1979, is the central agency within the Montana University System for establishing and intiating cooperative inter-institutional relationships among the units of the Montana University System on April 9, 1979, is the central agency within the Montana University System for establishing and initiating cooperative inter-institutional relationships among the units at the Montana University System and the public and private colleges that desire to participate in coordinating resources and services pertaining to the aged.

Goals for the Montana Center of Gerontology at Montana State University include:

1. Promote instruction of personnel in the field of gerontology at the undergraduate and graduate levels as well as offer non-credit educational and training programs;
2. Stimulate, create and coordinate opportunities for innovative, multidisciplinary inter-institutional efforts in educational instruction in the area of adult development and aging;
3. Develop, carry out and publish results of research projects in gerontology. Types of activities will include evaluation studies associated with short- and long-term training, as well as basic research and the development of position papers;
4. Provide consultation and technical assistance in gerontologically related topics to public, private and volunteer organizations;
5. Service as a repository for information and knowledge concerning the field of gerontology. In addition, serve in liaison and supplier capacities, regarding available resources on aging, between educational institutions, private organizations, the public, and federal, state, and local governments;

6 In cooperation with existing placement services, assist trainees in the individual gerontology programs to obtain information about and to acquire, where possible, employment in the field of gerontology;

7. To undertake the lead responsibilities in collaborating and initiating cooperative endeavors among the three existing gerontology centers and assist in the development of gerontology at other post-secondary educational institutions. Full use will be made of the resources and activities available at all cooperating institutions, and the contributions from unique programs will be recognized and encouraged; and

8. Where appropriate, deal with local, state and federal agencies, educational institutions, and private and volunteer organizations to establish cooperative research, education, training and service programs.

A-6-2 State Library - The State Library's Division for the Blind and Physically Handicapped utilizes volunteers through the Retired Senior Volunteer Program. Approximately 67% of the patrons of this division are over 65. Services are free of charge and include talking books (records), cassette books, braille books and the appropriate machines.

A-7 Other State Level Agencies -

A-7-1 Montana Health Systems Agency (HSA) - This private non-profit corporation contracts with the Federal Government and is responsible for writing the health plan for the State. Their planning committees work closely with the State Health Planning and Development Agency.

A-7-2 Montana Nursing Home Association - A non-profit organization representing 50 nursing homes (approximately 1/2 of the State's nursing homes).

A-7-3 Montana Association of Homes for the Aging - A non-profit organization representing a group of non-profit homes (including nursing homes) serving the elderly in Montana.

A-7-4 Montana Foundation for Medical Care - A physician directed, non-profit corporation designated by the Federal Government as the Professional Standards Review Organization (PSRO) for the State of Montana in May, 1975. The PSRO contracted with Montana

Social and Rehabilitation Services in April, 1976, to do medical and utilization review of long-term care facilities. In July, 1977, this responsibility was converted to the PSRO. Current contracts with Montana Social and Rehabilitation Services include pre-admission screening certification, ambulatory claims review and prior authorization of medical equipment and ambulance transport.

A-7-5 Montana Hospital Association - A non-profit trade association representing all of the general hospitals in the State of Montana (a total of 61), 29 of these hospitals are combination hospitals and nursing home facilities.

A-7-6 Mental Disabilities Board of Visitors - Responsible directly to the Governor's Office; this group of five (5) board members is charged with review of patient care, patient rights, and active treatment in the five (5) State institutions providing services to the mentally ill and developmentally disabled in Montana.

APPENDIX B

LISTING OF MONTANA SERVICES

APPENDIX B

B-1 A SUMMARY OF SERVICES CURRENTLY AVAILABLE STATEWIDE

Certain services are generally available on a state-wide basis, these services include the following:

Medical Services

Physicians - 1,113 physicians serve Montana

Hospitals - 63 hospitals (at least one in most counties) provide inpatient and outpatient service

Nursing Homes - 99 nursing homes provide an adequate distribution state-wide.

Drugs - A network of 160 pharmacies state-wide provide access to this service.

Physical Therapy, Occupational Therapy and Speech Therapy - limited by number of practitioners

Social Services - Social Services are available state-wide through county welfare offices and State district offices. Services include institutional placement, counseling and adult protective services.

Information and Referral - Available state-wide through a toll free number to citizen's advocate located at Governor's office.

Congregate Meal Sites and Meals on Wheels - A fairly comprehensive network of Title III nutrition projects. 121 congregate meal sites state-wide served 787,599 last year, while home delivered meals totaled 303,582.

Visual Services - Available state-wide through State district offices.

Nursing Home Ombudsperson - Available state-wide.

B-2 Services Available in Selective Areas and Limited in Quantity Include:

Home Care Services

Home Health Agencies - Certified Home Health Agencies serve about 1/2 of the state. See Exhibit B-1 for location.

Homemaker Services - Available through local welfare offices and area aging agencies state-wide but in limited quantity.

Personal Care Services - Available state-wide to Medicaid recipients if ordered by a physician and supervised by an R.N. This program appears to be growing. Requires recruitment of personal care provider.

Mental Health Center Services - Five major sites: Billings, Missoula, Great Falls, Glendive and Helena.

Adult Foster Home - There has been a dramatic increase in this area due to the effort of the social workers hired in the prescreening project. There are 160 adult foster homes state-wide.

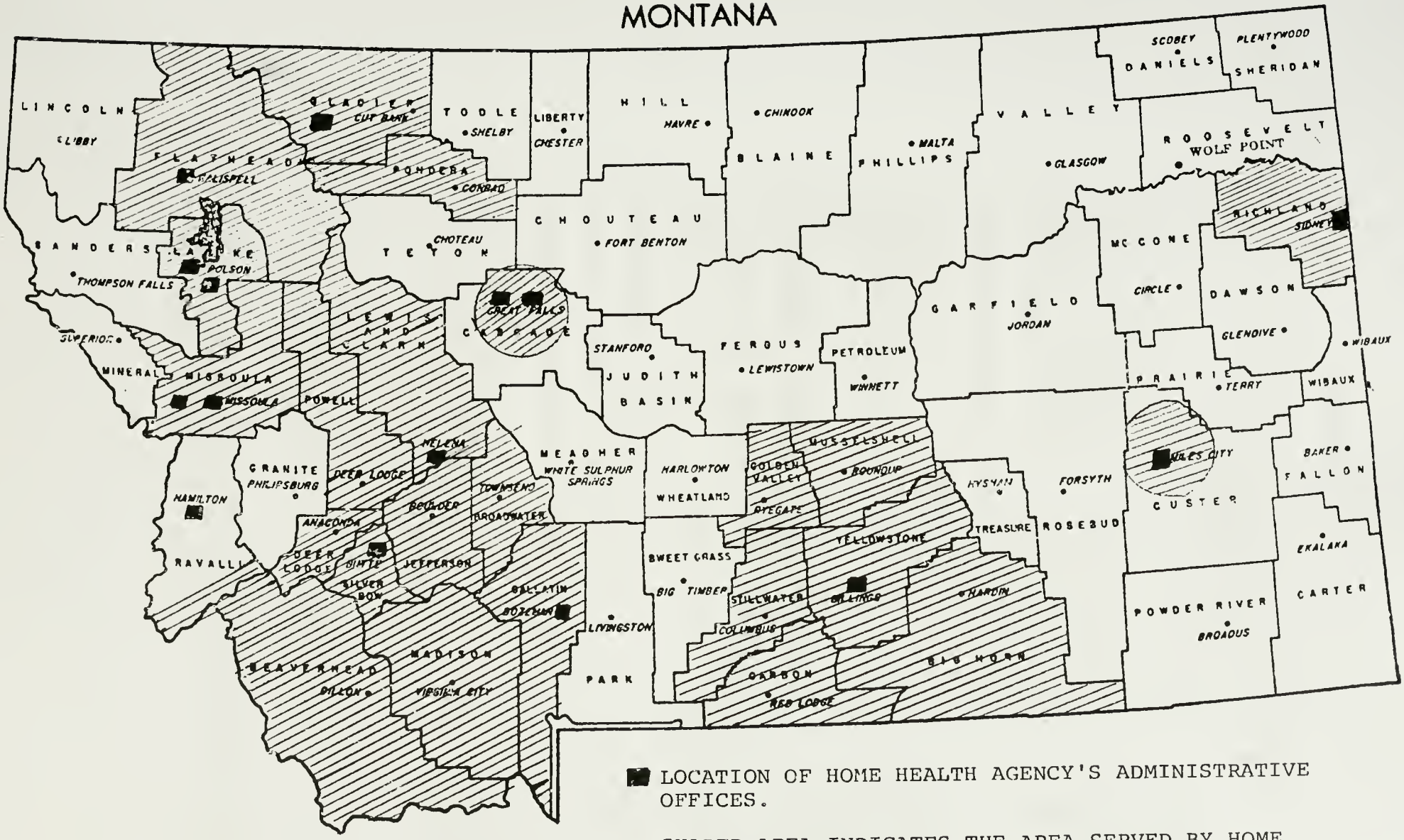
Pre-Admission Screening Services Available in selected areas.

Transportation Services - Limited primarily to medical care for Medicaid recipients. Available to the public for general purposes state-wide but in a limited quantity.

Congregate, Supervised Living Arrangement - Extremely limited, a small number in Missoula due to county supplementation.

Retirement Homes - Limited primarily to the larger cities.

Housing Options - Limited state-wide to low-income elderly.



■ LOCATION OF HOME HEALTH AGENCY'S ADMINISTRATIVE OFFICES.

SHADED AREA INDICATES THE AREA SERVED BY HOME HEALTH AGENCY

EXHIBIT - LOCATION AND CATCHMENT AREAS OF HOME HEALTH AGENCIES IN MONTANA (1980)

EXHIBIT B-1

APPENDIX C

DESCRIPTION OF MONTANA PROGRAM EXPENDITURES FOR LONG-TERM CARE

APPENDIX C

C-1 Major programs funded by Federal/State source

Social Services Title XX (FY 1979)

Home Attendant Services	948,767
Health Related Services	13,691
Adult Foster Care	62,579
Information/Referral	229,891
Institutional Placement & Counseling	217,675
Protective Services	502,560
Total Budget for Adult Services	1,975,163

Medical Assistance Title XIX (FY 1979)

Pre-Admission Screening - 2 yr. appropriation.	510,000
Nursing Home	29,390,582
Inpatient Hospital	10,393,597
Outpatient Hospital	1,115,244
Drugs	2,498,463
Home Health	238,795
Total Medicaid Budget	53,886,575

Nursing home expenditures are primarily for the elderly. Other listed expenditures include a significant number of elderly but are not exclusive.

Aging Bureau (FY 1979)

Resources supporting Title III	3,391.052

Department of Institutions

Veterans Home	921,440
Center for the Aged	1,571,883
Warm Springs Hospital	10,556,385
Galen Hospital	4,852,909
Boulder River School and Hospital	8,190.415

Visual Services (FY 1979)

Visual Service Rehab program	125,000
Visual Service Medical - 100% State funds.	50,000

The Division has applied for an independent rehabilitation grant to establish independent living projects state-wide. Potential funding 200,000

Department of Labor (FY 1979)

Overall budget - $177,000 of which 15% was expended on aged protection	27,000

Montana Center for Gerontology

Expenditures since 1976	126,000

Veterans' Affairs Division

Personal Services	313,479
Total Budget	375,197

APPENDIX D

MISSOULA PROPOSAL

BOARD OF COUNTY COMMISSIONERS
MISSOULA COUNTY COURTHOUSE
Missoula, Montana 59801
(406) 721-5700

RECEIVED
MAY 27 1980
E.A.—SRS

Jack Dorner, Program Manager
Medical Assistance Bureau
Department of Social and Rehabilitation Services
P.O. Box 4210
Helena, Montana 59601

Dear Mr. Dorner:

Enclosed with this correspondence is the Missoula County Council on Aging response to the locally Based Channeling Demonstration project. This includes the response to the criteria as well as the prelimary needs assessment which the council has developed for the comprehensive planning process. This response is late in terms of the date established in your correspondence, however Missoula County has been "shut down" since May 18, 1980. This included lack of mail service until May 22,1980 which was the date we received your correspondence. Therefore, I would appreciate every consideration you can provide.

Please don't hesitate to contact my office if you have any questions regarding this matter.

Sincerely,

John DeVore
Grants Coordinator

LOCAL CRITERIA FOR LONG-TERM CHANNELING PROJECT

The Missoula County Council on Aging is a non-profit corporation established to plan, coordinate, administer, and develop programs to respond to the needs of the elderly resident of Missoula County. The Council is composed of seven members appointed by the Missoula County Commissioners, and ten ex-officio members. The Council has also established an inter-agency council to provide technical input and coordination of all services impacting on the elderly. The ex-officio members and inter-agency council presently represents the following agencies and interests:

Nursing Homes
Social and Rehabilitation Services
YWCA
Health Department
Nutrition
R.S.V.P.
Senior Center
Indian Center
Housing Authority
University of Montana
Special Needs Transportation
I & R
County Welfare Department
Community Action Agency
Alcohol Programs
Mental Health
Western Montana Radio Reading Service
Area Agency on Aging
City of Missoula
County of Missoula
League of Women Voters

Presently the Council directly administers funds in excess of $125,000 to operate programs directly and contract for services. The following represents the types of services presently either suggested by or coordinated with the Council:

1. Nutrition Project which includes the following services:

Nutrition - Congregate/Home Delivered
Outreach
Counseling
Telephone Reassurance
Transportation
Nutrition Education

2. Senior Citizen Center

   Transportation
   Home Chores
   I & R
   Arts and Crafts
   Recreation
   Outreach
   Telephone Reassurance
   Taxis
   Shopping Assistance

3. Indian Center

   Arts and Crafts
   Outreach
   Transportation
   Telephone Reassurance
   Shopping Assistance
   Counseling

4. Western Montana Radio Reading Service

   Provides consumer education and current information to the visually impaired.

5. City/County Health Department

   Home health services

6. STS-Transportation

   Provides special needs transportation to the handicapped elderly.

7. R.S.V.P.

   Provides support services to enable senior citizens to volunteer their services. Present capacity is 200 volunteers and 35 work stations.

8. Community Action Agency

   Provides services in the area of crises intervention and weatherization services.

The above list does not include the general assistance provided through the County Welfare Department, employment services through Green Thumb, the Foster Grandparents project, or the programs provided directly through SRS. However, these programs do participate in the overall planning and coordination effort.

The Council is presently in the process of conducting a needs assessment survey among the providers and the initial results indicate that present service capability is responding to approximately 15 to 20 percent of the existing level of need. If expansion of services was to respond to the functionally impaired client, sufficient resources would have to be identified which would increase service levels in the areas of home health, home chores, home delivered meals, special needs transportation, and housing rehabilitation. Also, expansion of support services in terms of shopping assistance, telephone reassurance, friendly visiting and escort service would have to be dramatically increased.

The present management of the services in Missoula utilizes the County Council in terms of a focus to manage the resources to contract for various needed services. If this project would be developed within Missoula County, the County would designate the City/County Health Department as the local agency to coordinate and implement the project.

MANAGEMENT PLAN: "CHANNELING" DEMONSTRATION PROJECT

Presently, the Missoula County Council on Aging is an administering, planning, and coordinating agency for all aging funds allocated to the County. This involves the coordination of all grant applications through the utilization of the Council as the submitting grantee agency. The Missoula County Commissioners are currently working with the Council and all aging service providers to use the Council as the "Channeling" agency to administer all funds appropriated for aging services by the County. This process should be in place by September of 1980. Once the total process is complete, in terms of consolidating all grant functions, the Council will advertise RFP: for specific services which were identified through the planning process. After the contracts have been awarded to the various social service providers, the Council monitors and evaluates the delivery of services under each contract. This function is performed by the Council Aging Coordinator, and the members of the Evaluation Committee.

Currently, the Council contracts with the Missoula County Commissioners for a portion of the Missoula County Grant Coordinator's time. This involves the donation of office space, equipment, printing, xeroxing, postage, telephone, and secretarial support by the County. The above provides a fair reflection of the current process employed for the administration of funds received by the County under Title III B & C of the Older Americans Act. This same process would be implemented, if the County were awarded funds under the "Channeling" Demonstration Project. In effect, the Council would administer all funds received for the project and then sub-contract the program functions to a local agency. Since the criteria for the local agency in the RFP indicate specific functions which must be accomplished, the management calls for the awarding of a contract to the Missoula City/County Health Department as a sole source provider.

This would involve the delegation of the responsibility for the local agency activities through an approved work program and contract for services. The work program would specify how the local agency would propose to implement the project based on criteria established by the funding source. However, the work program and contract would require the establishment of a local advisory council composed of the following membership: County Council on Aging, City/County Health Board, Interagency Council, Nursing Homes, Community Action Agency, Senior Citizens Center, and the general public.

Proposed Budget:

The following budget figures represent minimum starting salaries for comparable positions under the County Salary Plan:

Position	Salary	Fringe 16.1%
Project Director	20,088	3,234
Case Manager	17,664	2,844
Social Worker	17,664	2,844
	55,416	8,922

MISSOULA COUNTY COUNCIL ON AGING

Contractors and Levels of Service in an Average Month

1. Missoula Nutrition Project

Number of Clients Served

Congregate Meals	145
Home Delivered	34
Transportation	19
Recreation	75
Outreach	4

Units of Service

Congregate Meals	769
Home Delivered Meals	770
Transportation	178
Recreation	8
Outreach	4

2. Qua Qui Corporation - Indian Center

Number of Clients Served

Congregate Meals	22
Home Delivered	9
Transportation	17
Telephone Reassurance	10
Outreach	13

Units of Service

Congregate Meals	286
Home Delivered	117
Transportation	38
Telephone Reassurance	22
Outreach	13

3. Missoula City/County Health Department - Home Health

Number of Clients Served

Blood Pressure	40
Personal Care	25
Skilled Nursing	85

Units of Service

Blood Pressure	40
Personal Care	25
Skilled Nursing	85

4. Missoula Senior Citizens Center

Number of Clients Served

Information and Referral	70
Outreach	25
Counseling	40
Transportation	135
Home Chore	72
Telephone Reassurance	60
Arts and Crafts	50

Units of Service

Information and Referral	70
Outreach	32
Counseling	50
Transportation	814
Home Chore	172
Telephone Reassurance	80
Arts and Crafts	175

5. Western Montana Radio Reading Service - Consumer Education and Information to the Blind and Print Handicapped

Number of Clients	230
Units of Service	174

6. STS - Transportation (Handicapped Transportation)

Number of Clients	333
Units of Service	1,000

ATTACHMENT II

MISSOULA COUNTY COUNCIL ON AGING

Coordination with Other Agencies and Levels of Service in an Average Month

1. Missoula Rehabilitation Center

	Clients Served	Units of Service
Physical Therapy	137	1,374
Occupational Therapy	27	274
Speech Pathology	15	150
Audiology	31	31
Nursing	32	32
Psycho Therapy	65	65
Social Services	4	4

2. Foster Grandparents

	Clients Served	Units of Service
	19	1,520

3. District XI Human Resource Council

	Clients Served	Units of Service
Weatherization	10	25
Fuel Assistance	56	215
Advocacy	10	25

4. Montana Legal Services Association

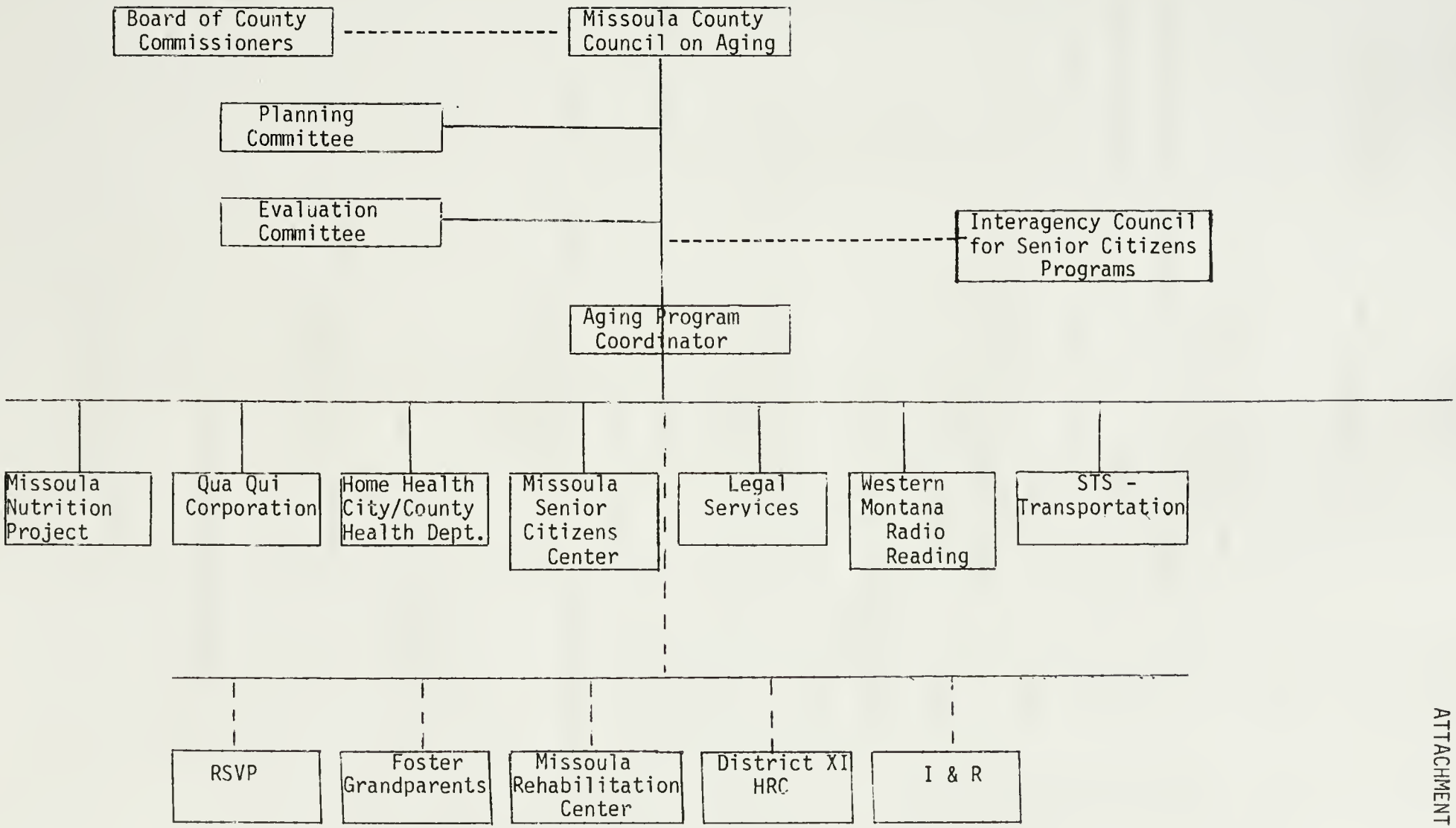
	Clients Served	Units of Service
Civil Legal Work	15	25

5. R.S.V.P.

Number of Clients Served	230
Number of Volunteer Stations	32

ADMINISTRATION OF AGING PROGRAMS

Missoula, Montana



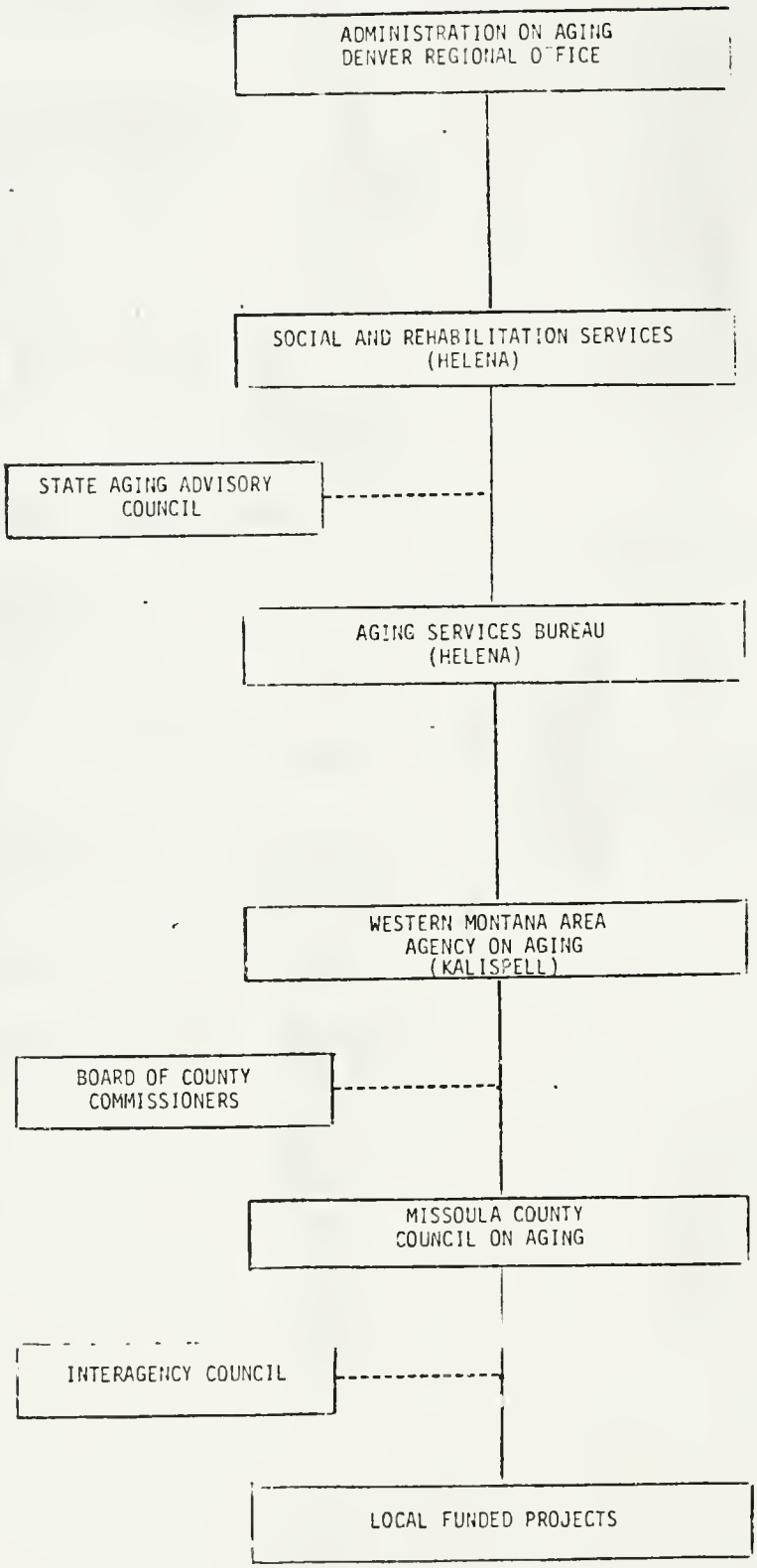
———— Denotes Direct Contract Relationship

---------- Denotes Coordination Relationship

ATTACHMENT III

Attachment IV

OLDER AMERICANS ACT FUNDS
FLOW CHART



NEEDS ASSESSMENT

The needs assessment component of this plan is intended to provide the best available information about the elderly resident of Missoula County at the present time, and to identify the basic weaknesses in existing data. The plan modifications section will delineate a strategy for improvement regarding data collection about the elderly in subsequent years. The needs assessment component is divided into two sections, namely statistical information and the results of a provider survey collected during May of 1980.

Statistical Information:

Since the basic information regarding the elderly resident of Missoula County is a result of the 1970 census, this element of the plan must rely on updates and interpretations developed by the Department of Community Affairs, the Department of Social and Rehabilitation Services, the University of Montana, Bureau of Business and Economic Research, as well as the Missoula County Planning Department.

The population of the Missoula County elderly population has grown dramatically since 1960. In 1960, Missoula County had 5,552 individuals over the age of 60, or 12.4% of the total population (Table I, page Appendix 1). In 1980, the elderly population of Missoula was 8,206 or 11.3% of the population. While these percentages indicate a relatively constant senior population, they represent a 47.8% change between 1960 and 1980. Consideration must also be given to the percent change in the overall population for the same period, which will indicate if this growth among the 60-plus population is comparable to the total. Between 1960 and 1970, the overall population grew at a rate of 30.5%, while the senior

population increased by 14.4% for the same period.

However, during the 1970's, the overall population increased by 24.4%, while the 60-year and over population increased by 29.1%. These changes indicate Missoula County is comparable to National statistics in terms of indicators which demonstrate the average age of our population is increasing. This average factor is projected to increase substantially on a National basis; and because of the present trends in the Missoula population, it could be concluded this will be true locally. Because basic funding decisions are made on a state and area agency level through the use of allocation formulas which weight the 60-plus factor, it is important to consider Missoula's senior population in relationship to the area and state. The current area agency plan indicates there are 24,100 individuals in the seven county area agency over the age of 60. This reduces to Missoula County containing 34% of the region's 60-plus population. The state has a total projected senior population of 110,000 which reduces to Missoula County containing 7.5% of the senior population within the state. These percentages will have to be monitored when resources are allocated to insure Missoula County is allocated resources in relationship to its senior population.

The period of 1960 to 1980 has also shown an increase between the male/female ratio among the target group. In 1960, the female senior population in Missoula was 4% higher than the male. This increased to 8% in 1970, and in 1980 it is 11% (Table II, page Appendix I). This also indicates Missoula is comparible to national statistics, which demonstrate women have a much longer life expectancy than men. This factor must be taken into consideration in existing and planned services, since it will change the scope and type of services required in the

future. Table III, page Appendix I, presents the 1980 60-year and over population projection in five-year intervals for men and women. This will be used for Missoula County, since it represents the most recent projections and will be cited as the figures for developing and implementing services in Missoula County until the 1980 census information is released.

Income statistics for senior citizens in relationship to the total population are not available for the past decade. The 1970 census information is still utilized and will be until the 1980 information is available. However, the 1970 poverty indicators for Missoula County demonstrate the overall poverty level is 11.2%, while the rate for individuals over age 65 is 23%. If this indicator, in terms of the age group over age 65, was true in 1970, it could be concluded that the disparity is far greater in 1980. The 1970 information was gathered prior to double digit inflation, and when consideration is given to the value of the 1980 dollar in relationship to the 1969 dollar, the impact to the elderly can be shown. The 1970's saw inflation hit hardest at the basic necessities of life--food, housing, transportation, and medical costs. Since the senior citizen generally lives on a fixed income, this target group can least afford to deal with the impact of inflation. The Social Security Administration indicates that in 1976 there were 4,852 beneficiaries in Missoula County over the age of 65 (Table IV, page Appendix I). This report goes on to demonstrate the average monthly income paid was $178 or $2,136 annually. This is well below the 100% poverty level for a family of one, based on the Community Services Administration guidelines. Therefore, when all the above factors are considered, support is given to the issue that senior citizens would show a higher instance of poverty than the general population. This issue is a key factor in terms of planning services and the allocation of revenues to insure those in greatest need receive priority in obtaining services.

Summary:

The above information demonstrates that Missoula County's elderly population is increasing at a higher rate than the overall population. If this trend continues at the same rate, it could have a potential impact to the overall community in terms of the educational system, transportation, medical facilities, etc. Also, this information shows a growing disparity between women and men, which could require the development of specialized services to respond to the needs of women left alone. The poverty figures indicate a large disparity between the overall poverty rate and the senior citizens. Since the majority of seniors have a fixed income, they are the least likely group to identify the resources to deal with inflation. The only alternative is for the senior to sacrifice one basic need for another. This could lead to an effort to develop innovative approaches to lessen the burden of the rising cost of living.

The statistical information available has many problems in terms of identifying all the indicators necessary to present a fair reflection of the problems faced by the elderly. The majority of information available does not delineate age differentiation below the age of 65. The information is presented in age clusters up to the age of 65, then the information is presented in five-year intervals. This data collection issue must be addressed if quality information is going to be available for the planning and development of services for this target group.

Another key area in the data collection issue is population projections in terms of age clusters. Presently, the various state and local agencies responsible for population projections do not present information for senior citizens. This type of statistical information must be generated in subsequent years, if communities are going to have quality information to plan for the future. When a community's population shows a trend in terms of increased growth among the senior community,

this must be closely followed to insure the planned services will respond to the real needs. During the course of reviewing the information presently available, much was found to be inadequate or not available, particularly in the area of poverty indicators, i.e. ethnicity, housing, food stamps, general assistance, health, etc. This information is presently available on a state-wide basis, but either does not present the data in terms of age clusters or is not specific to a particular community.

Because of the problems associated with the statistical information, a provider survey was implemented to ascertain what services are presently available, the level of service provided, the gaps providers presently see in service delivery, as well as what problems the providers see as priority areas.

MISSOULA COUNTY ELDERLY
60 Years & Older

TABLE I

Population Comparison

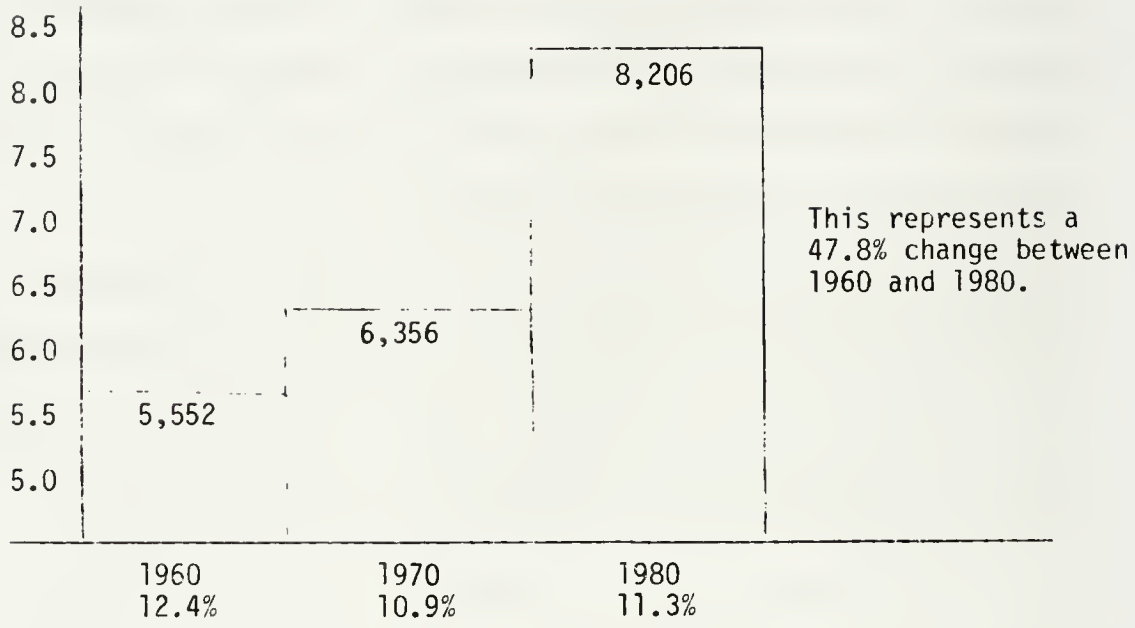
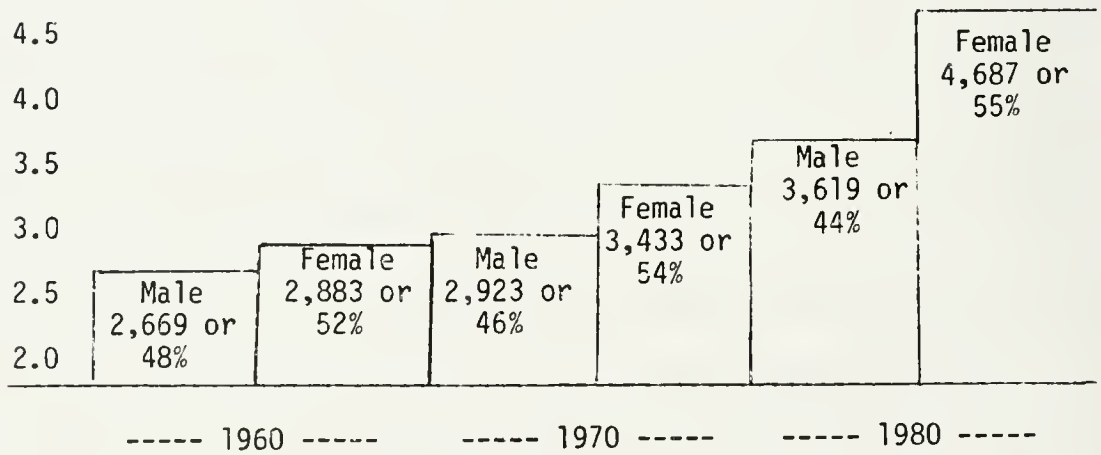


TABLE II

Population Comparison of 60 Years & Older by Sex



(Information Source: DCA - Montana Graphic Profiles, 1978
U of M - Bureau of Business and Economic Research)

TABLE III

Projected Population Distribution by Age & Sex for: 1980

Age Group	Total	Males	Females
60-64	2,597	1,197	1,400
65-69	2,083	943	1,140
70-74	1,475	653	822
75-79	1,024	424	600
80-84	615	244	371
85-89	412	158	254
Total	8,206	3,619	4,587

Total Projected 1980 Population for Missoula County: 72,500

Total Percentage Projected Elderly Population for 1980: 11.3%

TABLE IV

SOCIAL SECURITY BENEFICIARIES
Missoula County

Beneficiaries by Age Group:

	End of December, 1975	End of December, 1976
Age 65 to 71	2,061	2,118
Age 72 and over	2,648	2,734
Total	4,663	4,852

Benefits Paid	1) Benefits Paid End of December, 1975 (Dollars)		2) Benefits Paid End of December, 1976 (Dollars)	
	Year	Monthly Average	Year	Monthly Average
Age 65 and Over	$931,023	$166/mo.	$1,038,535	$178/mo.

1) This represents an average annual income from Social Security of $1,997 to the majority of persons 65 and over for 1975.

2) This represents an average annual income from Social Security of $2,140 to the majority of persons 65 and over for 1976.

Information Source: Social Security Administration, U. S. Dept. of HEW, Table A (unpublished data).

TABLE V

Persons receiving under the Federal SSI Program and under Federally-administered State Supplementation Programs, and amount of payments: June 1975, 1976, 1977

	June, 1975	June, 1976	June, 1977
Total Recipients	203	190	168
	Year - Monthly Average		
Payments	N/A	$54,474 - $68.35	$58,685 - $78.87

Information Source: Social Security Administration
U. S. Dept. of HEW

TABLE VI

HOUSING
Missoula County

Missoula Urban Area:	Total Owner Occupied
65 & Above	2,223

Number rated not good to poor: 685

Number rated not good to poor, 65 years and over, owner occupied: 133 or 19% of total.

Information Source: 1975 Missoula Housing Assistance Plan

APPENDIX E

ANACONDA PROPOSAL

AREA V AGENCY ON AGING

Serving the Counties of Powell, Madison, Beaverhead, Granite, Silver Bow, Deer Lodge

May 22, 1980

115 East Commercial Avenue
ANACONDA, MONT. 59711
406-563-3110

MEMO

RECEIVED
MAY 27 1980
E.A.—SRS

TO: JACK DORNER, PROGRAM MANAGER V, MEDICAL ASSISTANCE BUREAU, S.R.S.

FROM: JANE ANDERSON, ADMINISTRATOR JA.

RE: LONG TERM CHANNELING PROJECT

Enclosed for your perusal is information regarding the Area V Agency on Aging you requested in order to be considered for the Long Term Channeling Project Grant.

If you have further questions, please contact this Agency at 563-3110 or 563-3550.

LONG TERM CHANNELING PROJECT INFORMATION

The following is a list of lead Agencies involved with Area V Agency on Aging in providing direct and indirect adult services. This Agency has formal and informal agreements/contracts with those Agencies.

The first goal of this Agency is to provide a "Prescription of Services" which would prevent/reduce inappropriate/premature institutionalization by working "hand-in-glove" with City, County, State and Federal Agencies.

Agency receives referrals from:

1) Home Health care
2) Local Aging Programs
3) Hospitals and Nursing Homes (referrals for Home care services)
4) Housing (Public and Private)
5) Mental Health
6) Alcholism and Drug service
7) State institutions (Warm Springs and Galen)
8) County Welfare Departments
9) Vocational Rehabilitation
10) Veterans Administration
11) Social Security Administration
12) Butte/Silver Bow Anti-Poverty Council (winterization and energy)
13) Recreation Departments
14) Business at large, including food vendors
15) Center of Gerontology
16) Private Bar
17) Extension Service
18) County Health Departments
19) State Department of Health and Environmental Sciences (Preventive health)
20) Health Systems Agency
21) Montana State Health Coordinating Council
22) Law Enforcement agencies
23) Transportation systems
24) Physicians Services
25) Green Thumb
26) Employment Security (Job Service)
27) Job Corps
28) First Departments (City and Rural)
29) School systems (Adult Education)
30) Treasurer's office (Tax relief)
31) Clerk and Recorder's office (Homestead Exemption)

Description of Agencies providing services:

Area V Agency on Aging services:

1) Contract with Area V Home Health Agency, City/County Home Health Agency, Butte, to provide skilled nursing, Home Health Aide, Homemaker and other rehabilitative and maintenance services.

   These Home Health Agencies receive reimbursement from Medicare, Medicaid, Older Americans Act monies, State General fund monies and local tax dollars.

2) Nutrition services, (Congregate and home-bound) available in the Six County Planning and Service area of Area V Agency on Aging (direct service).

3) Access services include transportation and escort for those isolated medically handicapped persons (Direct service through contractural agreements and volunteers with local Agency projects).

4) Green Thumb (contract) to provide friendly visiting. shopping assistance, personal grooming and recreation.

5) Employment Security (contract). Community service aids to provide Staff for Home-Chore and Senior Center maintenance.

6) Butte/Silver Bow Anti-Poverty Council contracts for nutrition services for congregate and home delivered meals. Informal information and referral for winterization and energy assistance.

7) Butte/Silver Bow County Health Department (formal and informal support services).

8) Staff training Agreements with S.R.S. Aging Services Bureau, Center of Gerontology, Extension service, local educational institutions and Bureau of Nursing.

9) City and County public elected officials provide "match monies" for present and future planned services for the elderly under the Older Americans Act of 1965, as amended, Montana State legislated General Fund monies, and City/ County Revenue Sharing and General Fund monies.

10) City/County recreation Department scheduled and unscheduled activities available to handicapped and elderly.

11) Information, Referral and Follow-Up network for

Adult services. Formal and informal agreements with Veterans Administration, Mental Health, Alcohol and Drug, State and Local medical institution medical providers, Welfare, Housing, Law enforcement and emergency service personnel, Vocational Rehabilitation, Social Security, Easter Seals, Civic and Volunteer organizations.

DESCRIPTION OF EXISTING SERVICES

The following is a Summary description of services available to all elderly regardless of income:

1) Home Health care - Silver Bow, Madison, City of Dillon, Powell and Deer Lodge Counties.

2) Home-bound elderly and Handicapped Homemaker-Chore Services: Six County Planning and Service Area

3) In-home supportive services available to home-bound elderly and handicapped include: Homemaker-Chore service, shopping assistance, minor home repair, home delivered meals, and in-home meal preparation information, referral, outreach, friendly visiting, recreational supplies and Social Welfare counseling: Silver Bow, Madison, City of Dillon, Powell, Granite and Deer Lodge Counties.

4) Congregate meal sites strategically located throughout the Six County Planning and Service Area accessible to "pockets" of elderly.

5) Transportation and Escort available to some elderly throughout the Six County PSA (limited).

6) Staff training as required by the Older Americans Act and other funding regulatory agencies.

The Area V Agency on Aging administrative and advisory officials are in total agreement to sponsor the following needed supportive services for the functionally impaired elderly. Based on Needs Assessments, individual case studies completed and public meetings, this Agency perceives the priority needs as follows:

Adequate R.N.'s to provide skilled nursing service in the rural sparsely populated counties. L.P.N.'s to provide in-home personal care services, homemaker-chore, respite care staff for occasional relief for family. A vehicle to properly transport handicapped and disabled. Mobile medical unit for rural health care. To promote the community resources to provide day care. Establish additional nutrition sites to meet the needs of the rural isolated elderly.

The framwork to provide services has already been established, coordination and linkages with resources available and established management personnel is available. Expansion of the following services is needed to support the channeling recipients especially in the rural isolated area. Special transportation, in-home supportive services including home health and homemaker chore, congregate and home delivered meals, special training. New services to be implemented respite and day care services.

The Board of Directors, Administrative Staff and Advisory personnel have established working relationships with the Department of Housing and Urban Development, Economic Development Administration and received funds which resulted in a building complex to house the Agency and all service delivery components for the Six County Planning and Service Area.

The Agency also worked with SRS Social Service Division to provide Title XX services. The Area V Agency on Aging has worked with law enforcements agencies to help provide an educational crime prevention program for the elderly.

Staff members of the Area V Agency on Aging are representatives to both the Sub-Area Council and Executive Board of the Health Systems Agency. The Agency is also represented on the State Home Health Agency Board and Montana State Health Coordinating Council.

Area V has established a working relationship with private Bar members to provide appropriate and effective low cost/no cost legal representation for the elderly and handicapped.

Relationships are established and on-going with: all emergency service providers; Department of Health and Environmental services; Health Prevention; and, Nursing Bureau.

This Agency was established in December of 1973. The Adminstrator has gone beyond the State and Region to garner resources and technology now available.

The following is a list of Sub-Contractors in Area V:

G-005-006	Powell County Transportation	Serves 210 people
G-005-007	Smelter City Transportation	Serves 1,200 people
G-005-008	Drummond Multi-Purpose Center	Serves 150 people
G-005-009	Philipsburg Multi-Purpose Center	Serves 200 people
G-005-010	Dillon Home Health	Serves 300 people
G-005-012	Smelter City Sr. Citizens Center	Serves 3,000 people
G-005-013	Powell County Home Health	Serves 300 people
G-005-014	Special Insurance and Tax Account	Covers Special Insurance and Tax as required by law
G-005-017	Beaverhead Outreach Project	Serves 50 people
G-005-021	Sheridan Service Center	Serves 150 people
G-005-022	Area V Home Health Agency	Serves 600 people
G-005-023	Area V Training Project	Arrange for training as required
G-005-024	Elderly Indian Community Service Project	Serves 25 people
G-005-027	Butte Program Coordinator	Serves 3,000 people
G-005-028	Hollow Top Senior Cit. Center	Serves 45 people
	Butte Nutrition	Serves 200 people daily

- - - - - - - - - - - - - - - - -

Direct Services by Area V Agency on Aging:

Anaconda Nutrition - 600 daily
Information and Referral Service - 300 people

EXAMPLE OF HOME-CARE

Female: Age 48: Lives in own home in Anaconda, Montana

Multiple Sclerosis.

Confined to wheelchair. Lives in own home with husband and two sons, ages 20 and 17. Husband and one son working. One son in High School. Husband has drinking problem which causes upset with children and patient. Every effort has been made to train family members to help support the patient.

Request from MS patient: To help maintain her in own home until youngest boy graduates from High School, One more year.

This woman has been a recipient of service since 1973. One of the main services the Agency has provided is psychological support.

The following professional support services are being provided:

Daily - R.N. or L.P.N. bathes, gives medication. Irrigates catheter and gets patient up and dressed.

Daily - Nutrition Outreach worker delivers hot meals and feeds patient. Handles any other personal care and shopping assistance.
Physical Therapist provides service twice a week.

Weekly- Homemaker cleans house and irons.

Catholic Community members wash clothes and provides friendly visiting.

Due to lack of funds and personnel this Agency has not been able to provide this service seven days per week. A properly equiped vehicle would enable this patient to take part in Community functions.

Financial hardship occurs when patient must pay for the same care on weekends.

Cost to Agency for care of patient five days per week, four weeks per month:

R.N. and L.P.N. - $87.00 x 4 =	$ 348.00
Meal cost - 75x5 - 3.75x4 -	15.00
Outreach - $3.38x5 - $16.90x4=	67.60
P.T. - $19.00 x2 - $38.00x4 -	152.00
Homemaker - $3.38 x 4 =	13.52
Total cost to Agency per month	$ 596.12

Cost of appropriate Nursing Home Care in Anaconda for M.S. patient - $1,600.00 per mo

EXAMPLE

SITUATION: Male-Age 65. Lives alone - rents three room apartment. Income is $2,980.00 per year. Rent and utilities average $85.00 per month.

PHYSICIAN DIAGNOSIS: Arthritis - Emphysema - Foot trouble - Anemia-Gastritis and Malnutrition.

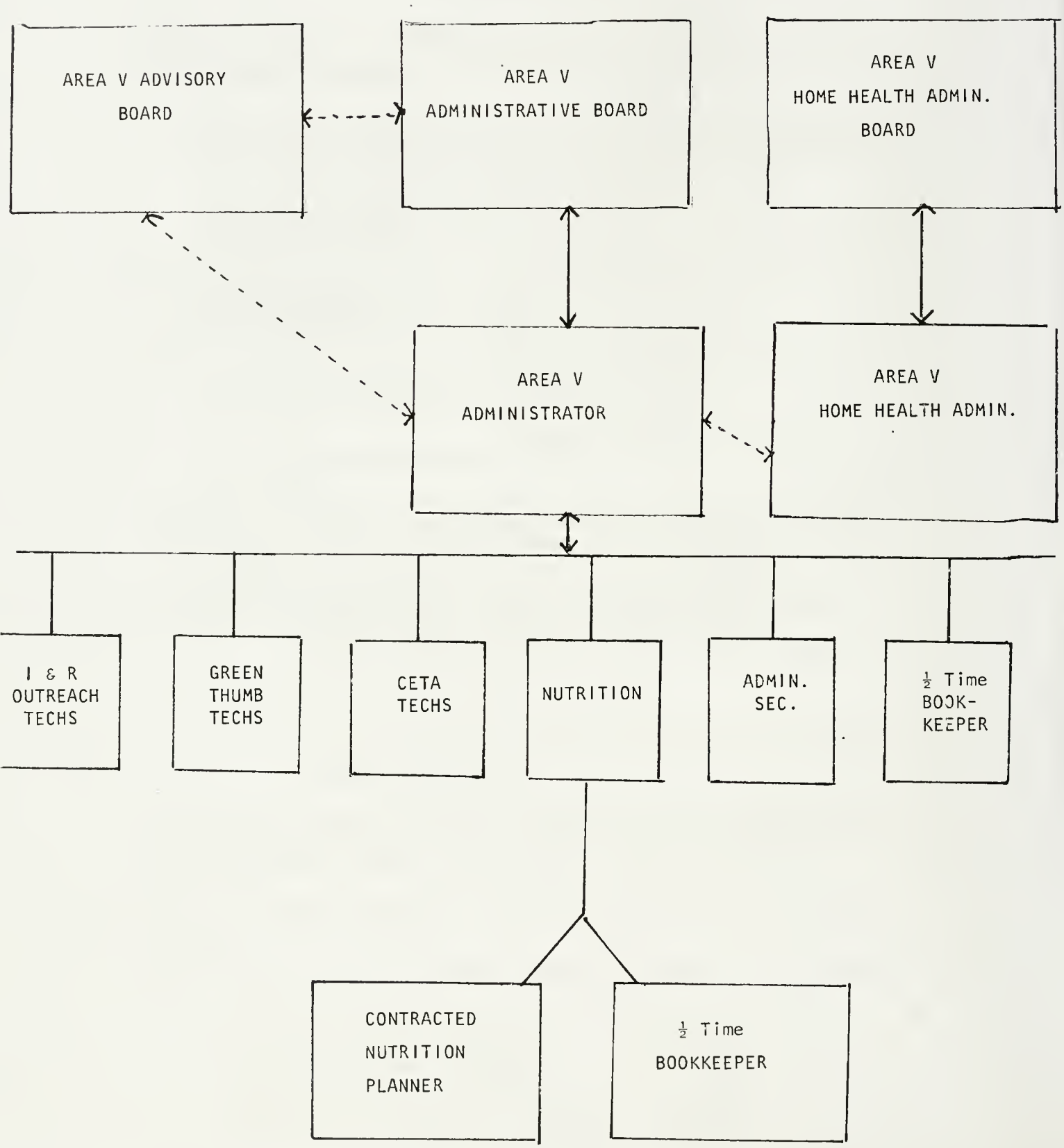
SERVICES RENDERED IN A THIRTY DAY PERIOD: 1) Transportation and Escort to a Podiatrist, Social Security office and Veterans Administration: 2) Six Home visits by R.N.; 3) Four house visits by L.P.N.; 4) One hot meal delivered five days per week; 5) One visit by Handyman to install safety equipment in bathroom; 6) Arrangements made for Food Stamps; 7) Homemaker cleaned apartment; 8) Outreach worker helped with grocery shopping; and 9) Volunteers provided needed clothing and bedding.

Cost to Agency - $245.00
Cost to Person - $ 28.50 (Podiatrist.)

RESULT: After thirty days of in-home care this man now rides a bus to a central facility and eats his noon meal, checks with Nurse. (Gets medication). Is now physically and mentally able to care for himself with a minimum of outside help. If these services had not been available he would have been hospitalized and probably institutionalized in a Nursing Home.

Planning and Service Area: AREA V AGENCY ON AGING Exhibit B-1a

AREA V ORGANIZATIONAL CHART



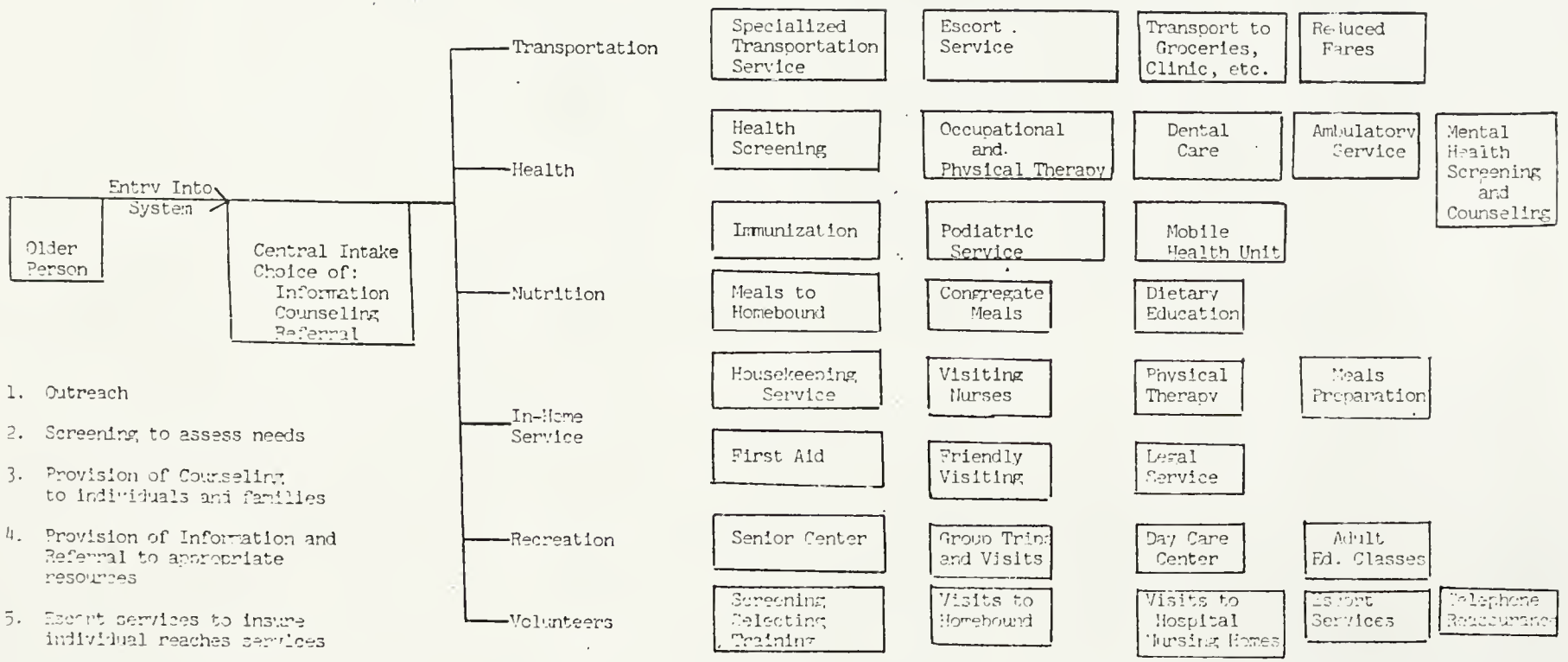
The Agency has addressed itself to the "Total Service - Need Situation" of older persons. Projects have been developed and are operated along the lines of the "Community Development Approach" (the movement of people and institutions jointly examining life in their community and taking action to enrich or improve it).

In service programming the planning entry is toward screening in - not out. The older person's expression of his/her problem as he/she sees it, has been accepted.

Planning started with the identification of an integrated range of specific service needs of individual older persons. Groups of older persons having the same needs were identified and service programs formulated.

To keep progressing, we do not wait for a "Perfect Data Base". We have chosen to use the best available data at a given time and build our program accordingly and, as our knowledge improves, we are able to adjust programs, shift an emphasis, phase an activity out, introduce another, and so on. This way we can remain flexible and responsive to the increasing needs of Seniors and are more effective in our pursuit for bringing about recovery, rehabilitation, self-care and independent living for older persons.

Gerry Halstead
Anaconda, MT.



1. Outreach
2. Screening to assess needs
3. Provision of Counseling to individuals and families
4. Provision of Information and Referral to appropriate resources
5. Escort services to insure individual reaches services
6. Follow-Up

AREA V AGENCY ON AGING
Six (6) County Planning & Service Area

A.) Beaverhead
B.) Madison
C.) Silver Bow
D.) Granite
E.) Powell
F.) Deer Lodge

PROJECT SITES AND TELEPHONE NO. CONTACTS

SENIOR CITIZEN SERVICES AVAILABLE

PROJECT SITES AND TELEPHONE NO. CONTACTS	INFORMATION & REFERRAL	OUTREACH	TRANSPORTATION & ESCORT	HOMEMAKER - CHORE	SKILLED NURSING SERVICES	FRIENDLY VISITING	CONGREGATE MEALS	HOME DELIVERED MEALS	RECREATION	LEGAL	HOUSING ASSISTANCE	SHOPPING ASSISTANCE	NURSING HOME OMBUDSMAN	BLOOD PRESSURE CLINICS	MULTIPURPOSE SENIOR CENTER	COUNSELING	EMERGENCY CRISIS ASSISTANCE	PHYSICAL THERAPY (homebound)	PODIATRIST CLINICS	PICTURE IDENTIFICATION	EDUCATION WORKSHOPS	SENIOR CITIZEN LEGACY	Opportunity for Choral Dev. (Professional conductor)
A.) Dillon - 683-4245	X	X	X	X	X	X		X	X	X	X	X		X		X	X					X	
B.) Pony - 685-3308	X	X	X	X	X	X	X	X	X		X	X		X	X	X	X					X	
B.) Ennis - 843-5466	X		X		X				X					X			X					X	
B.) Sheridan 842-5966	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X					X	
C.) Butte 792-4108	X	X	X	X	X	X	X	X	X		X	X		X	X	X	X			X		X	
D.) Philipsburg 859-3679																							
D.) Drummond 288-3312	X	X		X		X	X	X	X		X	X		X	X		X					X	
E.) Avon 492-6145	X	X				X	X	X	X		X	X		X	X		X					X	
E.) Elliston 492-7721																							
E.) Cold Creek 288-3432	X	X			X							X		X								X	
E.) Deer Lodge 846-3408	X				X							X		X									
F.) Anaconda 563-3504-Nutrition 563-3110-Agency 563-3550-Home Health	X	X	X	X	X	X		X	X	X	X	X		X		X		X	X			X	
563-5571 - Choral Conductor		X	X	X	X		X	X				X					X						X
	X	X		X	X	X			X	X	X	X	X		X	X	X			X	X	X	
		X	X	X	X									X				X	X				X

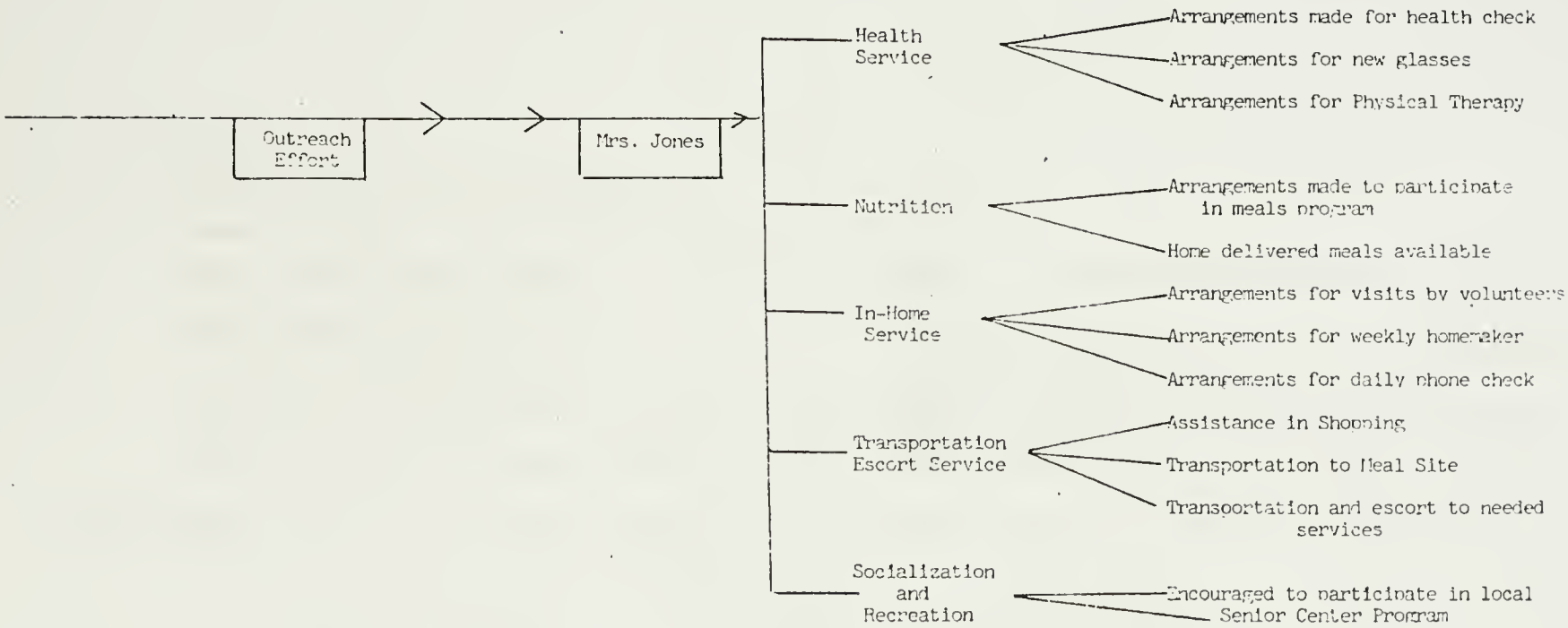
1970 Census

SUMMARY ANALYSIS OF PERSONS 60+ IN COUNTIES OF BEAVERHEAD, DEER LODGE, GRANITE, MADISON, POWELL AND SILVER BOW

COUNTY	TOTAL POP.	NO. OF PERSONS AGED 60+	% OF TOTAL POP.	NO. OF PERSONS 65+	% OF TOTAL	60+ INCOME LESS THAN $1,634.00	60+ INCOMES $1,634 TO $2,380	60+ INCOMES $2,380 TO $3,360	60+ WITH ONE OR MORE CHRONIC HEALTH CONDITIONS	60+ NEEDING IN-HOME SUPP-ORTIVE SERV.	60+ WITH LIMITED MOBILITY (TRANS.)	60+ DIFF-ICULT AMBULATORY
BEAVERHEAD	8,300	1,600	18.7	1,000	12.3	588	217	105	600	210	65	70
DEER LODGE	15,100	3,000	19.9	2,000	13.0	1,311	475	231	1,500	500	1,000	181
GRANITE	2,700	400	16.5	300	11.0	234	66	27	175	75	100	30
MADISON	5,900	1,100	17.9	700	12.4	155	83	66	450	132	460	64
POWELL	7,400	1,000	13.8	700	9.2	442	168	83	460	300	500	75
SILVER BOW	43,200	7,400	17.2	5,000	11.6	3,267	1,282	649	3,350	1,200	3,000	461
TOTAL	82,600	14,500		9,700		6,363	2,363	1,161	6,535	2,417	6,625	881

Area V Agency Planning Dept.
covering
Southwestern Montana

SENIOR SERVICE CENTER IN ANACONDA, MONTANA
SUPPORTIVE SERVICES FOR THE ELDERLY



Impact on Older Person	Impact on Community
IMPACT → Increased opportunity for involvement in Community Life.	Reduction or elimination of barriers to indepondent living.
Availabilitv of services and living arrangements suited to his needs.	Increase in number and scope of orivate and public agencies serving the elderly.
Opportunity to develop roles and interests that contribute to personal development.	Strengthening of existing service systems to assure provisions of comprehensive service.
Economic distress alleviated by provision of service at no or low cost.	Maximum effective utilization of existing public and private resources.
Great assurance of remaining in own home.	Availabiltity of coordinated pattern of service deliverv.
Increase in mobility.	
Increased access to needed health and social services.	
Reduction of isolation.	

APPENDIX F

LETTERS OF SUPPORT

montana foundation for medical care

P.O. BOX 5512 2017 AIRPORT WAY HELENA, MONTANA 59601

PHONE (406) 443-3020 1-(800) 332-3411

June 10, 1980

James W. Bay, M.D.
Jack A. Buss, M.D.
Douglas W. Bridges, M.D.
Thomas W. Bush, M.D.
Lindsay M. Bassett, M.D.
E. Bottagisio, M.D.
James W. Childs, M.D.
Steve J. Fitz, M.D.
R. C. Hanley, M.D.
Dwight R. Hinderaker, M.D.
Robert A. Johnson, M.D.
C. J. McCarthy, M.D.
Richard T. Miller, M.D.
Jack A. Newman, M.D.
Stuart A. Reynolds, M.D.
Richard P. Sloan, M.D.
Robert M. Sr. Jr., M.D.
Donald H. Smith, M.D.
Robert B. Whiting, M.D.
A. Lewis Wolheim, M.D.
Warren S. Wilder, M.D.
Charles D. Hundley, Ph.D.
John W. McMahon, M.D.

Mr. Keith Colbo, Director
Department of Social and
Rehabilitation Services
P. O. Box 4210
Helena, Montana 59601

Dear Mr. Colbo:

We have reviewed certain aspects of Montana's Long Term Care Channeling Demonstration Project. In addition, Mr. Blewett of your staff has discussed the Foundation's role in more detail with our Executive Director and Joyce Steffeck, R.N., Facilities Review Manager. The Foundation agrees to serve as the agency to independently evaluate the effectiveness of the system for at least a sample of agency clients.

Although all actions of this nature are subject to approval by our twenty-one member physician Board of Directors, we will describe our involvement to them at our next meeting in July and indicate staff support.

Sincerely,

John W. McMahon, M.D.
Medical Director

Charles D. Hundley, Ph.D.
Executive Director

JWMCDH/jp

AREA V AGENCY ON AGING

Serving the Counties of Powell, Madison, Beaverhead, Granite, Silver Bow, Deer Lodge

115 East Pennsylvania Avenue
ANACONDA, MONT. 59711
406-563-3110

June 3, 1980

Mr. Jack Dorner, Program Manager V,
Medical Assistance Bureau, S. R. S.
P. O. Box 4210
Helena, MT. 59601

Dear Mr. Dorner:

The Area V Agency on Aging Board of Directors, Advisory Board and Administrative personnel have reviewed the Long Term Channeling Project Grant and are in agreement to support every effort to contract with the State of Montana, S.R.S. Department when/if they receive funding for this excellent concept of alternative to institutionalization.

I wish to thank you for giving this Agency the opportunity for input into the planning process of the proposal.

Sincerely
Lee Fitzpatrick

Lee Fitzpatrick, Chairman of
the Board of Directors,
Area V Agency on Aging

LF:jb

BOARD OF COUNTY COMMISSIONERS
MISSOULA COUNTY COURTHOUSE
Missoula, Montana 59801
(406) 543-5234

May 29, 1980
BCC-80-322

Mr. Walter Taylor, President
Missoula County Council on Aging
Courthouse Annex
Missoula, Montana 59801

Dear Mr. Taylor:

This correspondence is in regard to your organization's effort in obtaining the locally based "Channeling" Demonstration Project for the elderly residents of this area. We believe this project would not only serve the benefit of the larger community in terms of decreasing the cost of premature institutionalization, but will also serve the emotional well being of those functionally disabled senior citizens faced with the possibility of institutionalization. This project would also serve to maximize existing resources through the coordination of all existing and planned services.

Therefore, we support your efforts and understand that if this project were funded, the County Council would be designated the administering agency, and the Missoula City/County Health Department would become the lead agency.

We would appreciate being kept appraised of this proposal, particularly if the project is funded in terms of the actual plan for implementation. If we can be of any further assistance, please do not hesitate to contact our office.

Sincerely,

Wilfred V. Thibodeau, Chairman

Barbara Evans, Commissioner

Joseph N. Boyer, Commissioner

BCC:JD:ll

MISSOULA COUNTY

May 30, 1980

Mr. Jack Dorner, Program Manager
Medical Assistance Bureau
Department of Social and Rehabilitation Services
P. O. Box 4210
Helena, Montana 59601

Dear Mr. Dorner:

This correspondence represents the Missoula County Council on Aging's official endorsement and willingness to administer the locally based Channeling Demonstration Project being submitted by the Department of Social and Rehabilitation Services. We understand this project will involve the County Council as the administrator of this project, and the designation of the Missoula City/County Health Department as the local agency to coordinate and develop support services to the functionally impaired senior citizens residing in Missoula, Mineral, and Ravalli Counties.

We feel this project will definitely respond to a real need of senior citizens in Missoula, Mineral, and Ravalli Counties, and look forward to working with your agency if this project is funded.

If you require any additional information or have any questions, please do not hesitate to contact either myself or Mr. John DeVore.

Sincerely,

Walter J Taylor

Walter Taylor, President
Missoula County Council on Aging

WT:JD:ll

...MAKING A DIFFERENCE...

May 30, 1980

John DeVore
Grants Coordinator
Missoula County Courthouse
Missoula, MT 59801

Dear John:

This letter is to officially inform you that the Missoula City-County Health Department is interested in serving as lead agency for the locally based Channeling Demonstration project. Intensive community coordination and comprehensive services to the elderly have always been of the utmost priority to this agency, and we are looking forward to a positive response to your proposal.

If you are in need of further information or assistance, please do not hesitate to contact us.

Sincerely,

David Feffer
Health Officer

Crystal Day
Director of Nursing

CD/sjb

MISSOULA CITY-COUNTY HEALTH DEPARTMENT
301 WEST ALDER STREET MISSOULA, MT 59801
TELEPHONE 721-5700

HUMAN RIGHTS COMMISSION

THOMAS L. JUDGE GOVERNOR

SUITE 300 616 HELENA AVENUE

STATE OF MONTANA

(406) 449-2884

HELENA, MONTANA 59601

JUN 3 - 1980

May 30, 1980

TO: Jack Dorner
Economic Assistance Division, SRS

FROM: Raymond D. Brown, Administrator
Montana Human Rights Commission

RE: Information Relative to Services Provided to the Elderly

The Montana Human Rights Commission is responsible for administering the discrimination laws within this state. Part of our responsibility is to insure that the elderly are not discriminated against in the areas of employment, housing, financing, government services, and public accommodations. We also process cases for the Equal Employment Opportunity Commission which enforces the Age Discrimination in Employment Act.

As you are well aware, discrimination against older workers is a reality. In this sense and in any long-term proposals affecting the elderly, the involvement of the Montana Human Rights Commission and the enforcement of its laws are crucial. The Commission does support your "Long-term Care Channeling Project," and the following information is supplied at your request:

1. Characteristics of the target population: The Age Discrimination in Employment Act protects persons 40 to 70. The Montana Human Rights Act places no upper limit on age; therefore, all the elderly are served and protected by our law.
2. Evidence of the target populations needed for long-term care services: The Montana Human Rights Commission has received over 200 complaints of age discrimination since FY 75. Rulings by the Montana Commission prohibiting mandatory retirement have been issued.
3. Summary of services currently available: Investigate complaints of discrimination; to provide workshops and training to the target group for awareness of discrimination laws.
4. Summary of fiscal resources expended over the last fiscal year for services: Fiscal Year 1980's overall budget of the Montana Human Rights Commission was approximately $177,000. Of this, approximately 15 percent ($27,000) was expended for age protection.
5. Regulations or legislation: Title 49, Chapters 2 and 3, Montana Code Annotated.

RDB:jw

Department of Health and Environmental Sciences
STATE OF MONTANA HELENA, MONTANA 59601

May 27, 1980

A C Knight, M D, F C C P
Director

TO: Jack Dorner, Social and Rehabilitation Services

FROM: Wallace A. King, Health Planning and Resource Development Bureau

THROUGH: George M. Fenner, Hospital and Medical Facilities Division

RE: Information relative to "Long-term Care Channeling Project"

The following is a brief description of the SHPDA's responsibilities in long-term care for the elderly as requested in your memo of May 21, 1980.

The National Health Planning and Resources Development Act of 1974, and guidelines and regulations issued to implement it, require Health Systems Agencies (HSA) and the State Health Planning and Development Agency (SHPDA) to plan for a comprehensive system of long-term care supports. The recently enacted Older Americans Act requires the "development of planning linkages with HSA's designated under Section 1515 of the Public Health Service Act."

A more integrative, comprehensive financing system alone will not create a comprehensive system of long-term care supports. Effective planning can provide the first step toward establishing it.

Currently, information suggests that reimbursement practice limits the health care options available to the elderly and that they will make use of the services which are available, whether or not those services are fully appropriate to their needs.

The SHPDA, in cooperation with the SRS, delineated a study to be undertaken by JRB Associates, Inc., to analyze the current status of long-term care/support in Montana, the future social, mental, and medical needs of the elderly and chronically disabled, and an array of alternatives to address the needs facing the elderly population. The HSA and the SHPDA will address these issues, taking the study into account, in the current planning cycle both from a system/population based and policy analysis perspective. We are hopeful that these components for the respective health plans will be completed by October 1, 1980.

Both agencies are aware that they have inherited a system which is oriented toward the provision of institutionally-based, medical services and a system which, through its financing programs, expresses the proposition that achieving health is primarily a question of receiving medical care. The HSA and SHPDA

intend to set goals for the future based on a sound assessment of the population's needs. This option might mean, depending on the analysis, that alternatives to institutionalization might be both less costly and more appropriate to the needs of the elderly population.

Soon after the completion of the JRB study, the SHPDA will convene a task force to address long-term care. The task force will be responsible to plan for a long-term care/support system to maximize the dignity and choice of the elderly individual and the wise use of resources. From the long-term care analysis, policies will be developed by the task force and the State Health Coordinating Council. It is hoped that the development of creative policy will impact policy-makers to enact legislation which more effectively meets the needs of the elderly.

Good luck in regard to the demonstration project. It surely could be the answer to the cooperative, integrative, coordinative issues we have talked about over time through implementation of a formally-organized medical, mental health, social and personal care services system.

WAK:AA:dd

APPENDIX G

SITE SELECTION MATERIAL

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

THOMAS L. JUDGE, GOVERNOR

P O BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59601

PROPOSAL FOR A LOCALLY BASED

"CHANNELING" DEMONSTRATION PROJECT

1. Purpose: A federally funded project to be awarded in ten (10) states which will test the ability of local programs to arrange, manage, and coordinate provision of services so as to insure that people who need long-term care receive appropriate services in the least restrictive setting and in the most cost-effective manner.

2. Principle target population is the functionally impaired elderly.

3. Proposals for local demonstrations in rural areas, as well as in more densely populated communities, are being encouraged. However, sites selected for the demonstration must be capable of providing services to no less than 300 persons or no more than 800 persons in a year.

4. The project will be a joint venture among the federal, state and local agencies. The federal government is looking for a good comparative base among the ten selected states so it will have a heavy hand in defining many elements of each project and the evaluation of those projects.

5. Governors of states interested in developing a proposal are to designate a lead agency which is to establish a working group from Medicaid, Social Services, and Aging Services. Governor Judge has asked S.R.S. to be the lead agency.

6. The deadline for getting a proposal to Washington is June 14. The shortness of time requires us to work on several aspects at once. The state is in the process of writing many aspects of the application now. Obviously, this cannot be finished until we have one to three proposed local sites designated, with information concerning local ability to arrange, manage, and coordinate services.

"AN EQUAL OPPORTUNITY EMPLOYER"

7. To select the sites to be included in the proposal, S.R.S. is asking Area Director of Aging Services to help organize information about a local sites ability to meet certain criteria that are essential for the successful implementation of the demonstration.

8. The criteria are being prepared now, and will be put in the mail to you on Wednesday, May 14th. We are asking that you or another willing local lead agency put together the information needed to meet the criteria and get the material back to us by May 26th.

9. Between now and the receipt of the list of criteria, you can be identifying parties or coalitions that might be interested in working on this demonstration and advise them to be available to help put together the needed information. Obviously, locales that already have networks of interagency coordination, good utilization of existing resources, clearly identified gaps in services, and specific methods of impacting the target population will have the best chance for being selected as one of the demonstration sites.

10. The S.R.S. contact for this project is Jack Dorner (449-3952).

GB/lh

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

THOMAS L. JUDGE, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59601

Jack Dorner, Program Manager V
Medical Assistance Bureau

May 14, 1980

All Area Directors of Aging Services

Proposal for a Locally Based Channeling Demonstration Project

The enclosed material is submitted for your consideration in replying to the proposal entitled, "Proposal for a Locally Based Channeling Demonstration Project," as presented by Mr. Gary Blewett of the Montana Department of Social and Rehabilitation Services at your meeting in Helena May 9, 1980.

It is requested that your reply focus on the 5 criteria listed under "Local Criteria for Long-Term Channeling Project" (attached). It is suggested that your response be from 2 to 5 pages in length. Relevant attachments are encouraged if readily available. Your reply by May 26, 1980, is appreciated.

Enclosures I and V are taken directly from the RFP and explain the channeling concept and objectives. The "boilerplate" material has not been included.

The GAO report, "Entering A Nursing Home -- Costly Implications for Medicaid and the Elderly", will be sent under separate cover. The information in this report is relevant to the channeling concept and gives insight of why the government is interested in such a project.

If your agency is selected, further detailed information will be requested. If you have further questions, please contact me at 449-3952.

jls

Enclosures

"AN EQUAL OPPORTUNITY EMPLOYER"

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

THOMAS L. JUDGE, GOVERNOR

P.O. BOX 4210

STATE OF MONTANA

HELENA, MONTANA 59601

May 13, 1980

TO: All Area Directors on Aging

FROM: Jack Dorner, Program Manager V
Medical Assistance Bureau

RE: Local Criteria for Long-Term Channeling Project

1. Evidence of lead agencies involvement in providing services to the elderly, including provision of direct services and working relationships with other agencies providing adult services.

2. Description of agencies providing services to the elderly and evidence of inter-agency cooperation, including elected officials. Selection will be based on strength of such evidence.

3. Summary and description of existing services and their availability to the elderly.

4. Narrative on what services the lead agency perceives to be needed in supporting the functionally impaired elderly in the community and the framework in which a total array of services could best be arranged, managed and coordinated. Sites selected must be capable of providing services to no less than 300 persons or no more than 800 persons.

5. Evidence of support and willingness to work within federal and state guidelines and policy and with federal and state staff.

jls

STATE OF MONTANA
SOCIAL AND REHABILITATION SERVICES

INTER-OFFICE CORRESPONDENCE

FROM: Jack Dorner
Medical Assistance Bureau

Date May 27, 1980

TO: Norma Vestre, Holly Luck, Gary Blewett & Judy Carlson

RE: EVALUATION OF DEMONSTRATION SITES FOR LONG-TERM CARE CHANNELING PROJECT

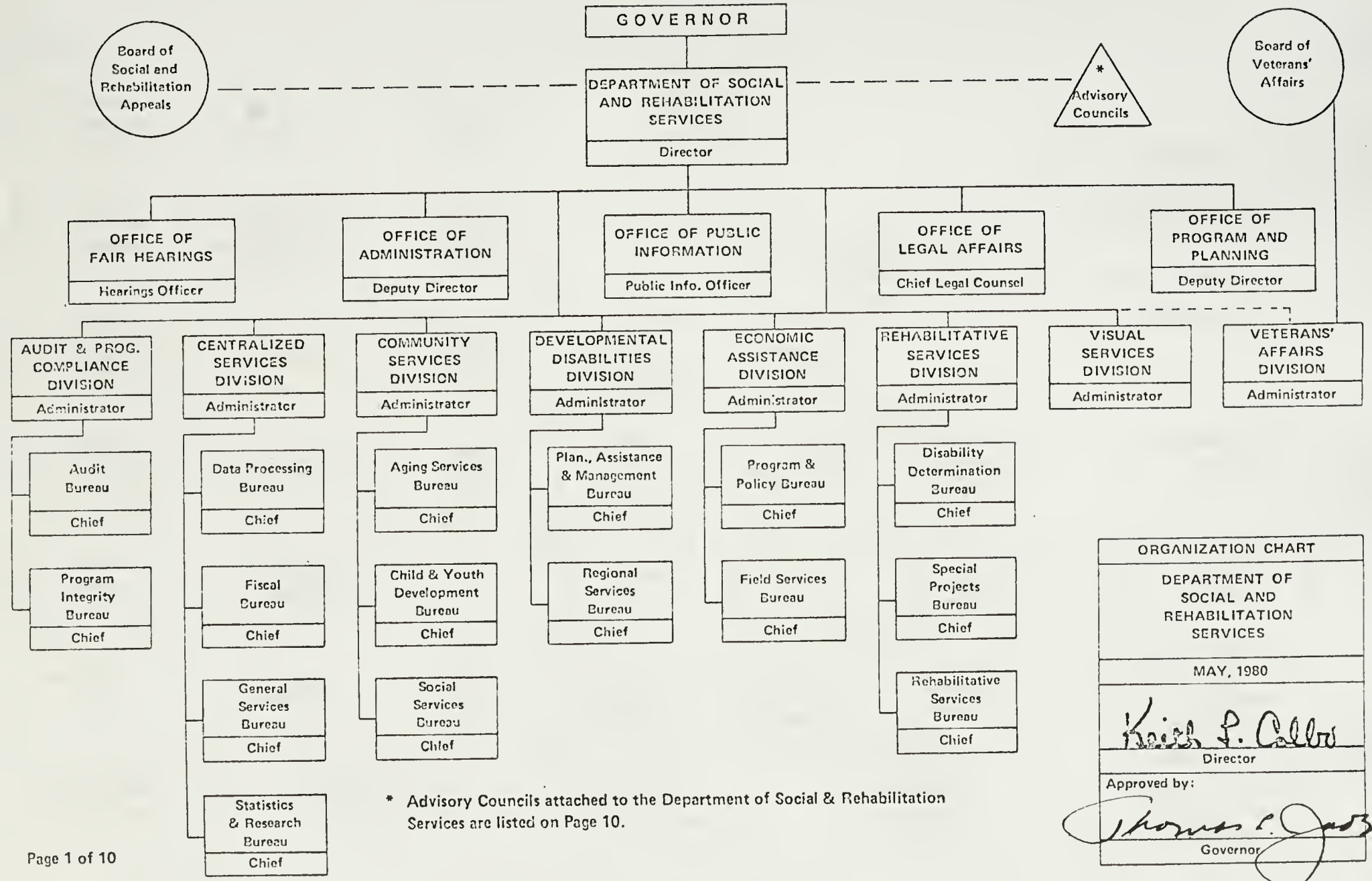
The following evaluation criteria are to be considered in selecting up to three (3) sites for the Long Term Care Channeling Demonstration Project.

Criteria	Numerical Weights
1. Commitment of Local Agencies to Long-Term Care Services.....	35%
1.1 Evidence of agencies involvement in providing services to the elderly.	
1.2 Working relationships with other agencies providing services to the elderly with emphasis on interagency cooperation, including elected officials.	
2. Availability and types of existing services in site area.....	20%
3. Technical Approach - Narrative description of the framework in which a total array of services could best be arranged.....	20%
3.1 Appropriateness of framework to the objectives of channeling project.	
4. Target Population.....	25%
4.1 In relation to the JRB study of areas appropriate to the channeling project, including the number of clients to be served (300 to 800).	

JD/lh

APPENDIX H

SOCIAL & REHABILITATION SERVICES
ORGANIZATIONAL CHART



* Advisory Councils attached to the Department of Social & Rehabilitation Services are listed on Page 10.

ORGANIZATION CHART

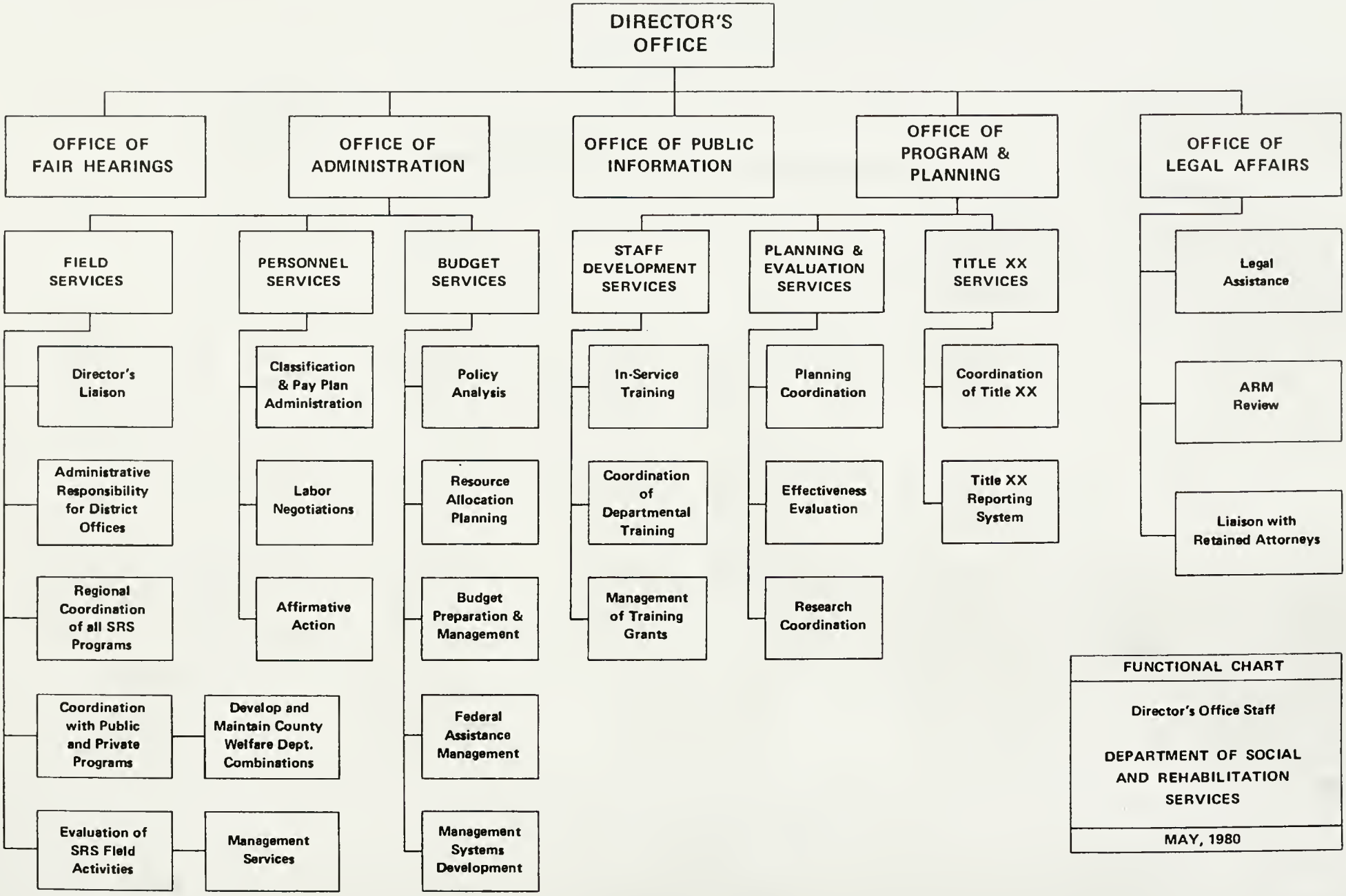
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

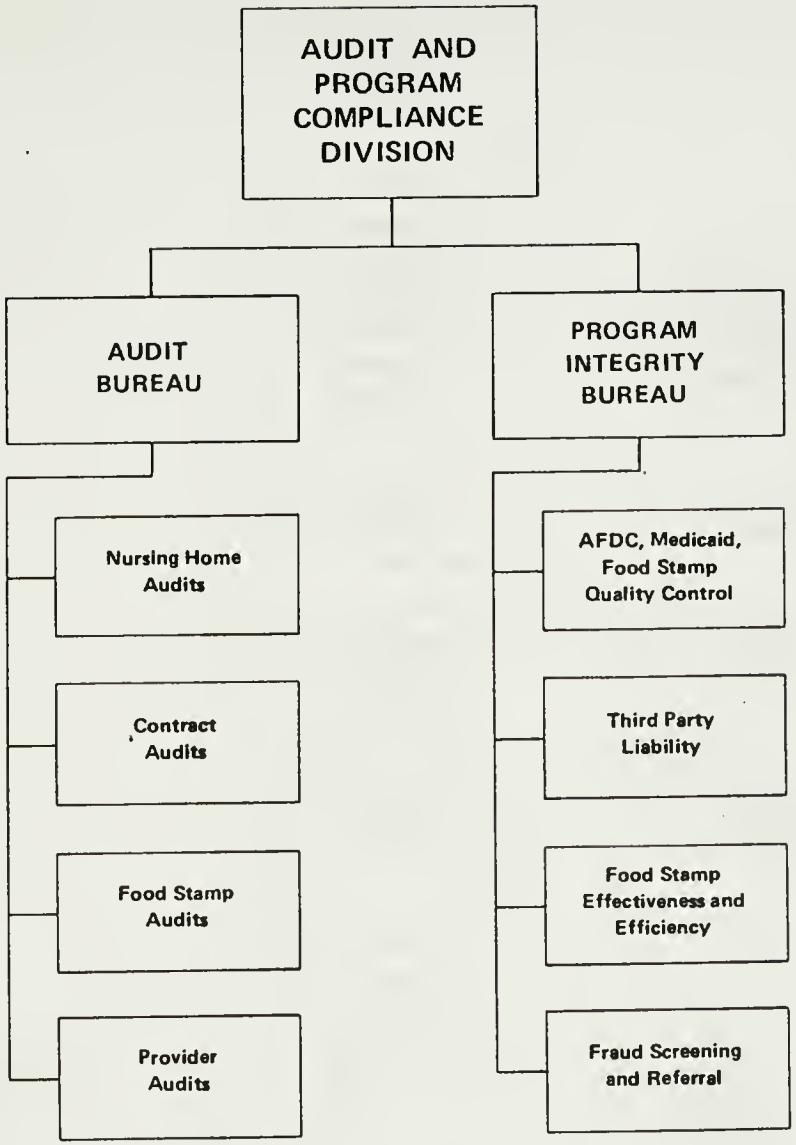
MAY, 1980

Director

Approved by:

Governor


DIRECTOR'S OFFICE
OFFICE OF FAIR HEARINGS
OFFICE OF ADMINISTRATION
OFFICE OF PUBLIC INFORMATION
OFFICE OF PROGRAM & PLANNING
OFFICE OF LEGAL AFFAIRS
FIELD SERVICES
PERSONNEL SERVICES
BUDGET SERVICES
STAFF DEVELOPMENT SERVICES
PLANNING & EVALUATION SERVICES
TITLE XX SERVICES
Director's Liaison
Administrative Responsibility for District Offices
Regional Coordination of all SRS Programs
Coordination with Public and Private Programs
Evaluation of SRS Field Activities
Develop and Maintain County Welfare Dept. Combinations
Management Services
Classification & Pay Plan Administration
Labor Negotiations
Affirmative Action
Policy Analysis
Resource Allocation Planning
Budget Preparation & Management
Federal Assistance Management
Management Systems Development
In-Service Training
Coordination of Departmental Training
Management of Training Grants
Planning Coordination
Effectiveness Evaluation
Research Coordination
Coordination of Title XX
Title XX Reporting System
Legal Assistance
ARM Review
Liaison with Retained Attorneys
FUNCTIONAL CHART
Director's Office Staff
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MAY, 1980

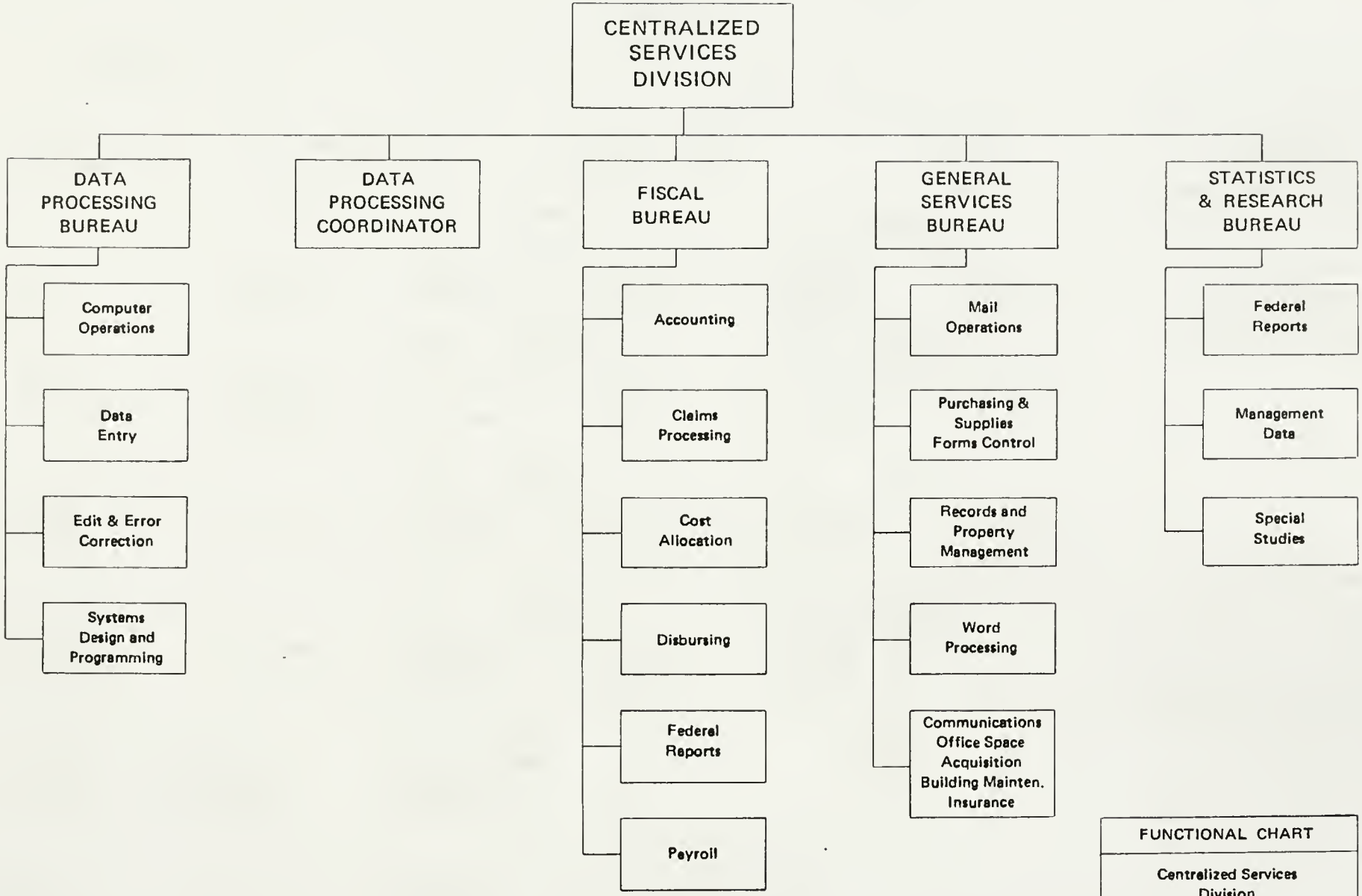


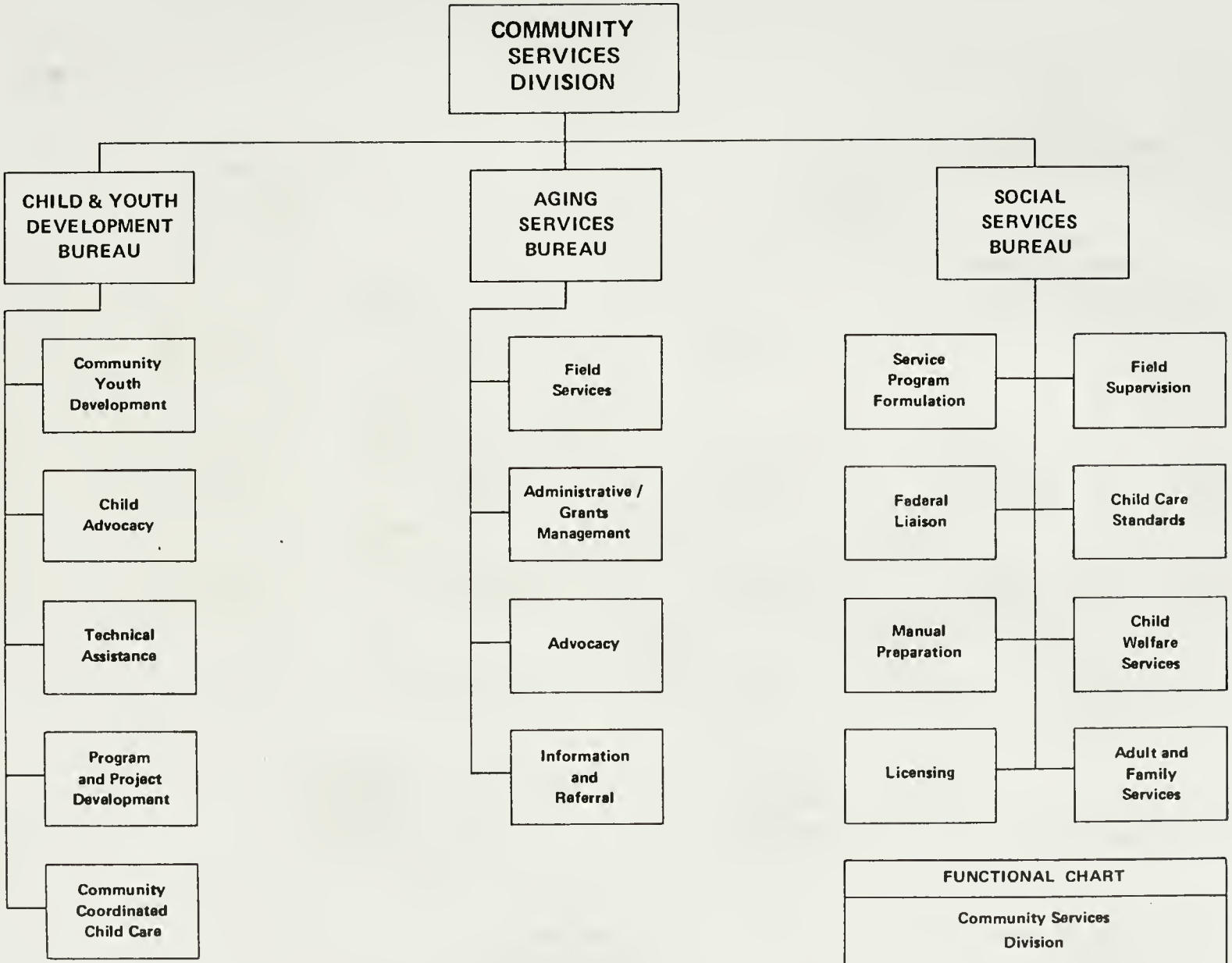
FUNCTIONAL CHART

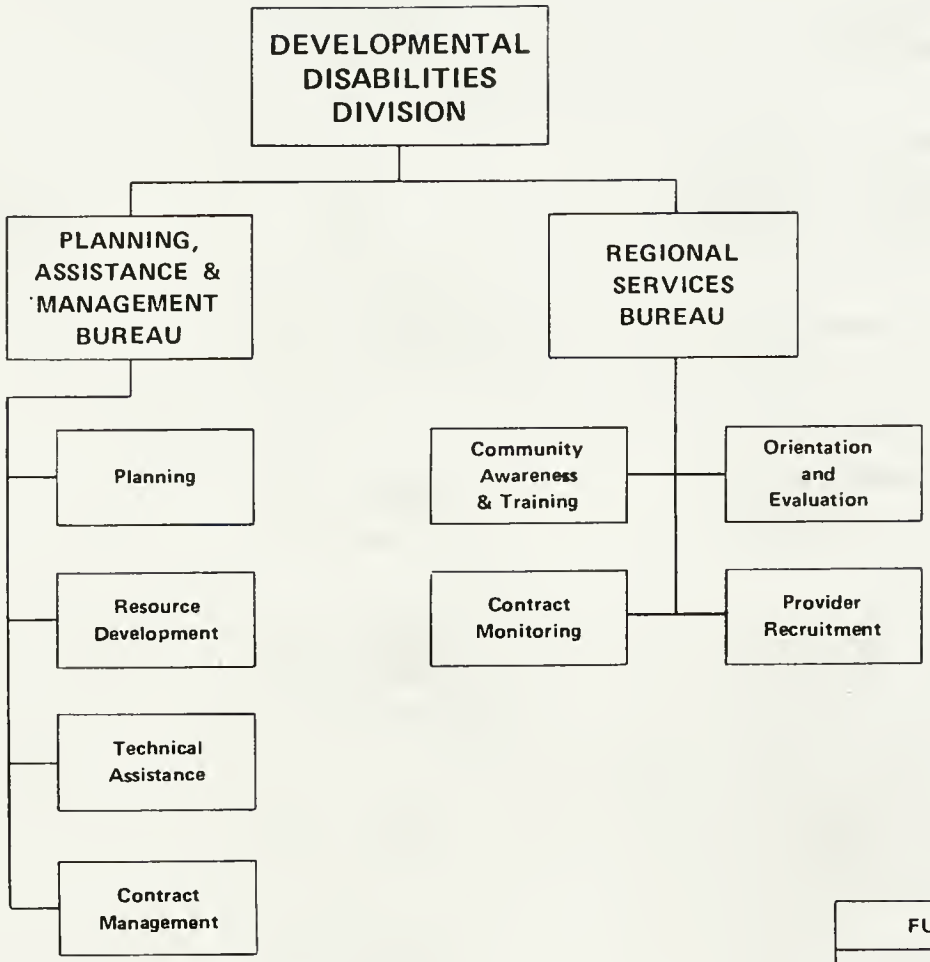
Audit and Program Compliance Division

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

MAY, 1980


CENTRALIZED SERVICES DIVISION
DATA PROCESSING BUREAU
Computer Operations
Data Entry
Edit & Error Correction
Systems Design and Programming
DATA PROCESSING COORDINATOR
FISCAL BUREAU
Accounting
Claims Processing
Cost Allocation
Disbursing
Federal Reports
Payroll
GENERAL SERVICES BUREAU
Mail Operations
Purchasing & Supplies Forms Control
Records and Property Management
Word Processing
Communications Office Space Acquisition Building Mainten. Insurance
STATISTICS & RESEARCH BUREAU
Federal Reports
Management Data
Special Studies
FUNCTIONAL CHART
Centralized Services Division
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MAY, 1980


COMMUNITY SERVICES DIVISION
CHILD & YOUTH DEVELOPMENT BUREAU
Community Youth Development
Child Advocacy
Technical Assistance
Program and Project Development
Community Coordinated Child Care
AGING SERVICES BUREAU
Field Services
Administrative / Grants Management
Advocacy
Information and Referral
SOCIAL SERVICES BUREAU
Service Program Formulation
Field Supervision
Federal Liaison
Child Care Standards
Manual Preparation
Child Welfare Services
Licensing
Adult and Family Services
FUNCTIONAL CHART
Community Services Division
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MAY, 1980

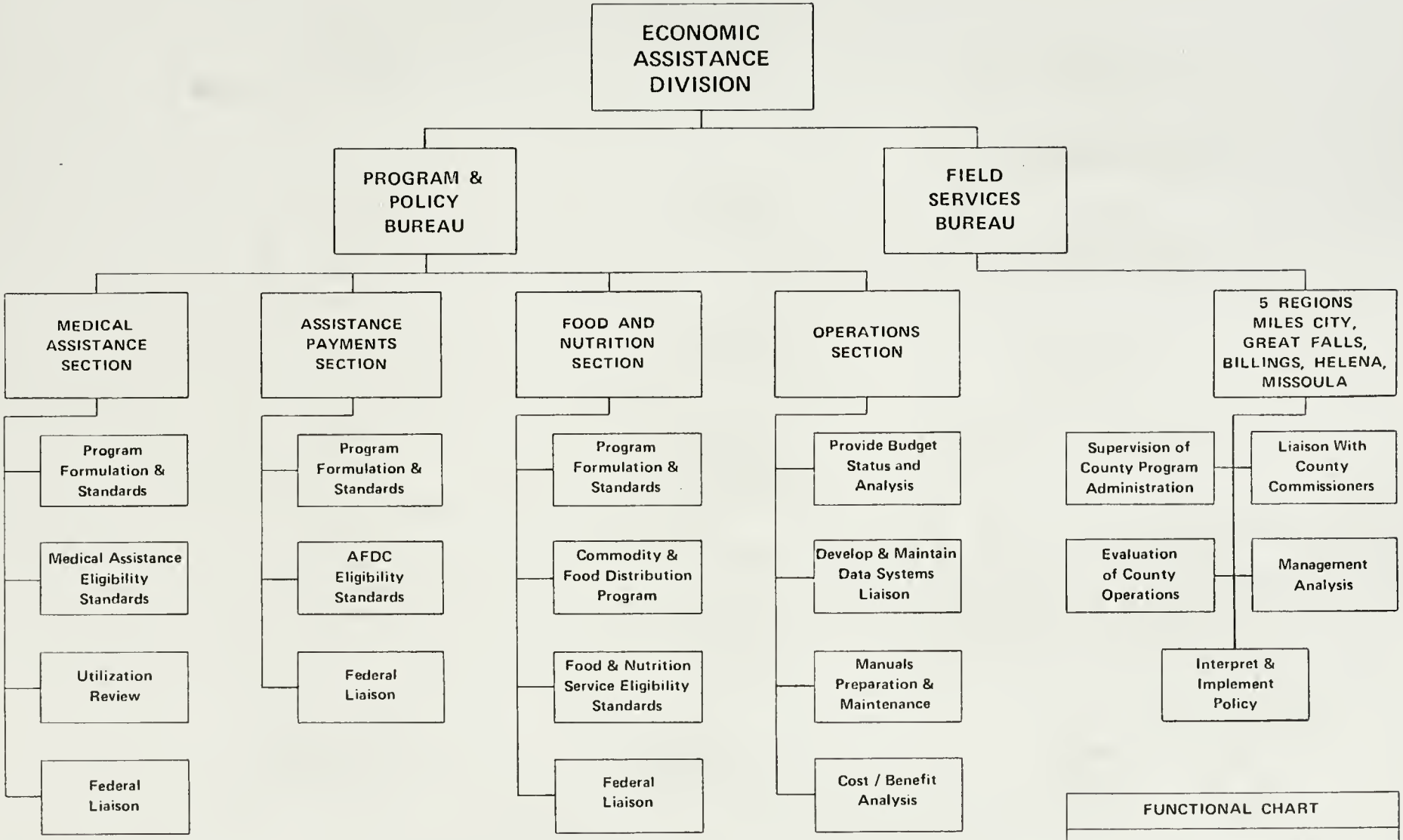


FUNCTIONAL CHART

Developmental Disabilities Division

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MAY, 1980

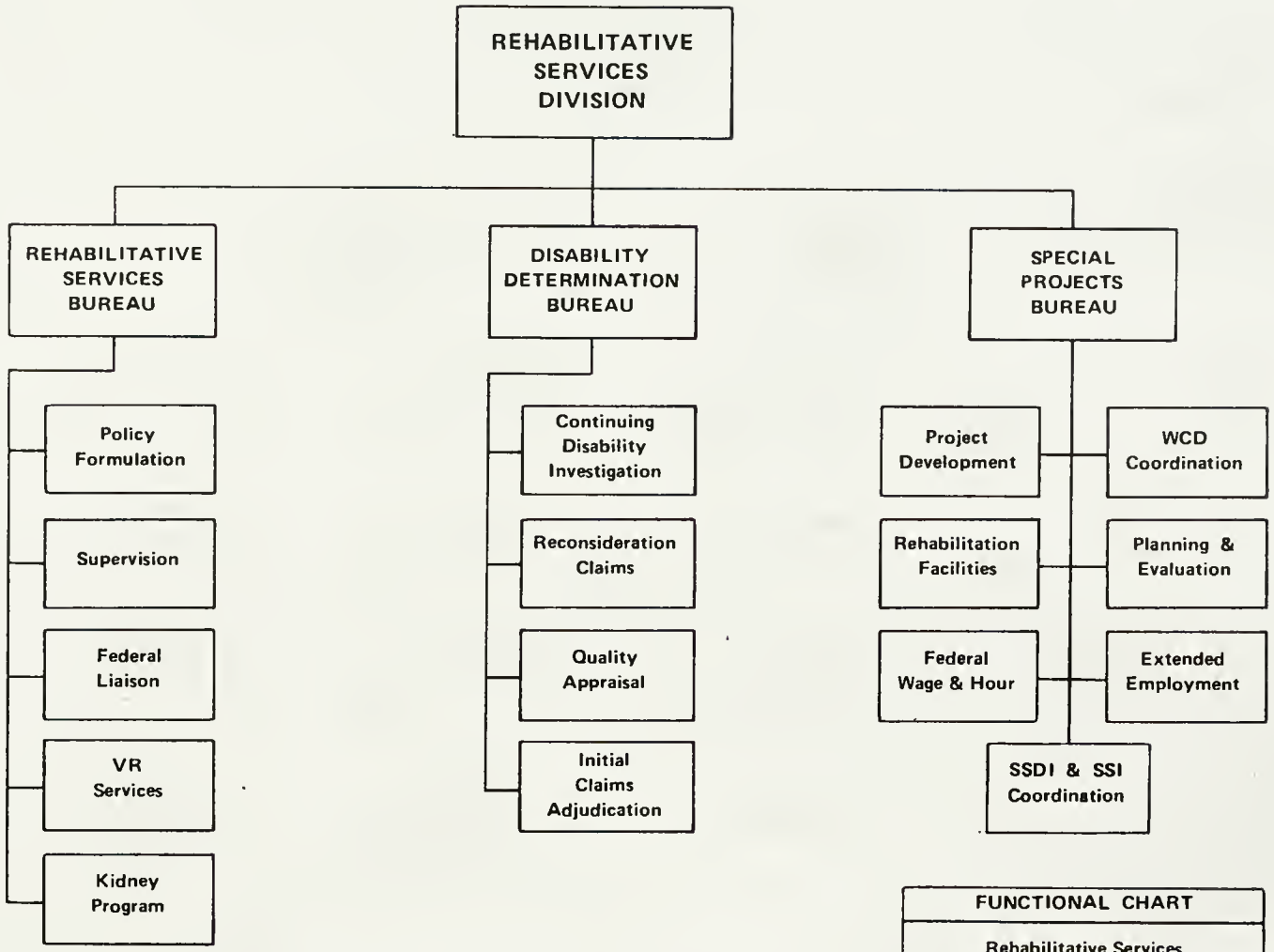


FUNCTIONAL CHART

Economic Assistance Division

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

MAY, 1980

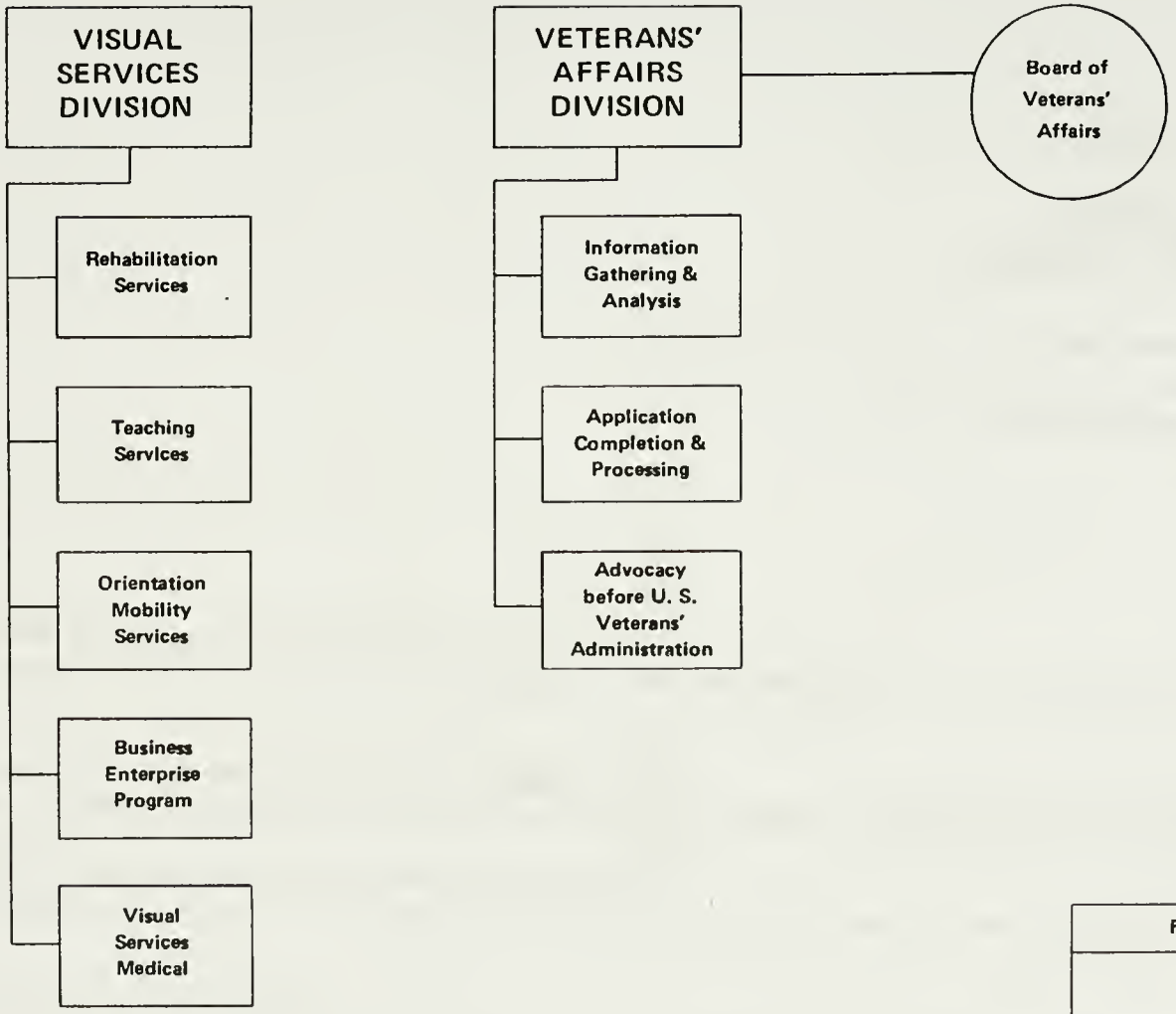


FUNCTIONAL CHART

Rehabilitative Services Division

DEPARTMENT OF SOCIAL & REHABILITATION SERVICES

MAY, 1980



FUNCTIONAL CHART

Visual Services
and
Veterans' Affairs
Divisions

DEPARTMENT OF SOCIAL
AND REHABILITATION
SERVICES

MAY, 1980

Aging Services Advisory Council — advises the Director of SRS on programs and the State Plan affecting Senior Citizens of Montana.

Medical Assistance Advisory Council — advises the Director of SRS on the Medical Assistance Program.

Rehabilitative Services Advisory Council — advises the Director of SRS on the problems of deaf, rehabilitation facilities, and general direction of the Rehabilitative Services Program.

State Developmental Disabilities Planning Council — a statutory planning council which advises the Director of SRS and all related agencies on all aspects of the developmental disabilities program planning.

Regional Developmental Disabilities Planning Councils (one in each of five regions) — assists regional staff with developmental disabilities program planning within their respective geographical regions.

Visual Services Advisory Council — advises the Director of SRS and the Visual Services Division on the problems of the blind and visually impaired and the Montana State Plan for services to the blind.

FUNCTIONAL CHART
Advisory Councils DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
MAY, 1980

APPENDIX I

PRE-ADMISSION SCREENING
&
ASSESSMENT TOOL

Type of Placement Made By Pre-Admissions Screening Teams

	Type of Placement			
	Appropriate Placement	Inappropriate Placement	Waiting for Placement	Total
Nursing Home	500	92	2	594
Personal Care	6	9	50	65
Room & Board	4	10	8	22
Foster Care	7	9	37	53
Retirement Home	16	12	10	38
Relative's Home	12	10	13	35
Own Home	22	26	1	49
Other	13	3	10	26
Total	580	171	131	882

Type Support Services Used, Needed & Available; Needed & Unavailable To Pre-Admission Screening Clients

	Using	Need & Available	Need & Unavailable
Meals	67	40	8
Chore Services	8	6	3
Home Health	60	23	33
Personal Care	24	19	38
Day Care	2	5	34
Physical Therapy	39	11	11
Occupational Therapy	9	3	2
Speech Therapy	3	1	5
Companion Services	5	3	13
Home Attendant	55	43	4
Transportation	45	24	3
Relative Support	211	11	15
Respite Care	2	5	26
Alcohol Services	7	9	6
Mental Health	23	15	1
Social Services	117	35	1
Other	17	4	11
Total	694	257	214

Total Respondents = 665

PREADMISSION SCREENING, DISCHARGE AND

ALTERNATE CARE PROGRAM

A significant number of patients presently in long term care facilities have been placed there not because of medical needs but rather because of a lack of community resources capable of meeting their needs outside of a long term care facility. These are people who require assistance in their activities of daily living whose families are unable to care for them or lack the resources to care for them. These patients include the elderly, disabled, mentally retarded, and physically handicapped.

The Department of Social and Rehabilitation Services and the Montana Foundation for Medical Care wish to implement the preadmission screening program described in ARM 46-2.10(18)-S11440 using funds available under Title XIX of the Social Security Act to assure the necessity and appropriateness of admission of such persons to long term care facilities, thus promoting better utilization of existing facilities and providing a means of identifying the resources necessary to provide adequate and appropriate health care to the community.

for all Medicaid eligible persons or Medicaid applicants requesting admission to long term care facilities participating in the Montana Medicaid program or referred

Where appropriate the recommendation of the medical social worker and the nurse coordinator will include a plan for alternate care. The plan will specify what resources will be used for alternate care and will indicate how the applicant's social, medical, and environmental needs will be met. An alternate care plan will not be approved by the screening team for a Medicaid recipient in a long term care facility if the resources required to effect the plan will cost more than eighty percent (80%) of the cost of nursing home care being paid at the time of the screening team's evaluation. It will be the responsibility of the Department to determine this alternate care cost ratio.

The attending physician will review the recommendation of the nurse coordinator and medical social worker and either confirm or contest it. When this decision is contested by the attending physician, he may negotiate with the physician advisor and the other members of the screening team to see if some mutually acceptable alternative can be developed. The decision of the physician advisor regarding the results of screening will be final for Medicaid payment purposes pending any appeal under subsection (I) below.

The decision of the screening team may be appealed in the manner set out in ARM 46-2.10(18)-S11440(1)(g)(i)(aae).

to the Foundation by the attending physician, county welfare office, long term care facility, or hospital in which the person is currently being treated to determine whether those persons are in need of the care provided in long term care facilities.

Hospitalized Medicaid eligible recipients or Medicaid applicants being considered for long term care placement upon discharge from the hospital will be screened by the screening team before placement is made. If the hospital provides Medical Social Services, the screening teams will coordinate their activities with the hospital's social work staff in such a way as to supplement services already provided and to avoid duplication of effort.

Whenever possible, screening will take place within 48 hours after a screening team receives a referral.

Nurse coordinators in cooperation with the attending physician and physician advisor when appropriate will make the initial evaluation of the applicant's medical needs. The medical social workers will make the initial evaluation of the applicant's social needs. The nurse coordinators and medical social workers will then confer and together recommend where the applicant can most appropriately be cared for.

STATE OF MONTANA
SOCIAL AND REHABILITATION SERVICES

INTER-OFFICE CORRESPONDENCE

FROM: Jack Dorner, Program Manager V
Medical Assistance Bureau

Date February 27, 1979

TO: All Medical Social Workers

RE: Instructions for Completing SRS Alternative Care Report Form EA-70

The Alternative Care Report Form consists of a duplicate page 1 (NCR paper) and a page 2 printed tumbler fashion on the back of page 1 copy.

Page 1 is to be completed and the original returned to the Medical Assistance Bureau. The copy of page 1 with page 2 printed on the back, remains with the worker. Reports are to be returned to Jack Dorner, Medical Assistance Bureau, Box 4210, Helena, Montana, 59601 on a monthly basis.

The boxes to be filled in are, in most cases, self-explanatory. Box 13, the Assessment Mode, may need some clarification. A complete assessment means an in-depth evaluation; complete medical and social information shared by team members; alternatives discussed; client and family interviewed; home situation observed; and recommendation arrived by a cooperative team approach. Telephone concurrence is simply a brief telephone discussion where limited information is shared. Limited assessement is an evaluation somewhere between the in-depth evaluation and the brief telephone contact.

If you have questions on completing this form, please contact me.

I am requesting that the form be filled out for persons screened as far back as you have information for the purpose of establishing a data base. Thank you for your cooperation.

jls

MONTANA DEPT. OF SOCIAL & REHABILITATION SERVICES

ALTERNATIVE CARE REPORT FORM

NAME: _____

ADDRESS: _____

REFERRAL SOURCE: _____ Date: _____

ADDRESS: _____

PHONE: _____

SPOUSE'S NAME: _____

ADDRESS: _____

BIRTHDATE: _____ PHONE: _____

SIGNIFICANT OTHERS (NAME, ADDRESS, PHONE):

ATTENDING PHYSICIAN: _____

PHONE: _____

1. SOCIAL SECURITY NO: ☐☐☐☐☐☐☐☐☐

2. DATE OF BIRTH: ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

3. SEX: ☐
M = Male
F = Female

4. MARITAL STATUS: ☐
S = Single
M = Married
D = Divorced
W = Widowed

5. CO. RESIDENCE: ☐☐

6. MEDICAL ASST. STATUS: (at time of assessment) ☐
1 = On medical assistance
2 = M.A. application pending
3 = Temporarily off M.A.
4 = SSI Eligibility

7. PERSON HAS BEEN LIVING: ☐
1 = Alone
2 = With spouse
3 = With relative
4 = With friend
5 = In foster home
9 = Other (specify)

8. CURRENTLY ESTABLISHED LIVING ARRANGEMENT: ☐

9. LOCATION AT TIME OF ASSESSMENT: ☐

1 = Private home
2 = Rented house
3 = Room
4 = Apartment
5 = Boarding house
6 = Personal care home
7 = Adult foster home
8 = Nursing home
9 = Hospital
0 = Other (specify)

10. DATE OF ASSESSMENT: ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

11. TYPE OF ACTION: ☐
1 = Prescreening, pre-admission
2 = Post-admission screening
3 = Discharge from nursing home
4 = Other

12. IF DISCHARGED, INDICATE LENGTH OF STAY TO NEAREST NUMBER OF MONTHS: ☐☐

13. ASSESSMENT MODE: ☐
1 = Complete team assessment
2 = Limited assessment
3 = Telephone concurrence
9 = Other (specify)

14. WORKER NUMBER: ☐☐

INITIALS: _____

DATE PREPARED: _____

15. TYPE OF PLACEMENT:
1 = Appropriate Placement
2 = Inappropriate Placement
3 = Desired Placement (unavailable) *
Blank = Not Applicable

☐ Nursing home
☐ Personal care
☐ Room & board home
☐ Adult foster home
☐ Retirement home
☐ Home of relative
☐ Own home
☐ Other (specify)

* Use only if a code 2 has also been used.

16. SUPPORT SERVICES:
1 = Already Utilized
2 = Needed for Alternate Placement (available)
3 = Needed for Alternate Placement (unavailable)
Blank = Not Applicable

☐ Meals (congregate or delivered)
☐ Chore services
☐ Home health
☐ Personal care
☐ Day care
☐ Physical therapy
☐ Occupational therapy
☐ Speech therapy
☐ Companion services
☐ Home attendant
☐ Transportation
☐ Support of relative or neighbor
☐ Respite care
☐ Alcohol services
☐ Mental Health
☐ Social Services
☐ Other (specify)

PHYSICAL EVALUATION:

● Primary Diagnosis: _____

Secondary Diagnosis: _____

● Activities of Daily Living:

	FUNCTIONAL STATUS								AMBULATION			
	Taking Medication		Personal Care	Dressing / Bathing	Household Chores		Using Phone	Toileting / Cooking	Walks w/o Aids		Transferring	Wheeling / Stairs
Independent												
Needs Assistance												
Dependent												
Restoration Potential												

WT. BEARING

	Right	Left
Full		
Partial		
Non		

● Impairments:

	Vision	Hearing	Contractures	Dentition / speech
Normal				
Limited				
Severe Impairment				
Restoration Potential				

	Incontinence - urine	Incontinence - stool	falling
Never			
Seldom			
Often			
Restor. Potential			

● Comments on Special Needs or Devices: _____

EMOTIONAL STATUS:

	Depressed	Anxious / Fearful	Lonely	Withdrawn / Alert	Angry / Hostile	Guilty	Forgetful	Abusive / assaultive	Wanders	Confused	Impaired judg.	Agitated day / agit. night
Never												
Seldom												
Always												
Rest. Potential												

● ORIENTATION:

	Time	Place	Person
Yes			
No			
Sometime			

● Restraint Orders: ☐ Physical - Applied ☐ Siderails/Gerichair ☐ Chemical

● Comments: _____

LIVING ARRANGEMENTS:

● Appropriateness of Current Living Arrangement: _____

● Patient's Attitude Toward Change: _____

● Significant Others' Attitude Toward Change: _____

● Nursing Home Placement: Recommended: ☐ Social Worker ☐ Nurse Coord. Not Recommended: ☐ Social Worker ☐ Nurse Coord.

● Recommendations *(including discharge plan or alternative)*: _____

REPORT PREPARED BY: _____

(SIGNATURE OF SRS SOCIAL WORKER)

APPENDIX J

PRELIMINARY RESULTS, ALTERNATIVES STUDY

1. Study Summary
2. Report # 1: Literature Review
3. Report # 4: Survey Findings and Status Report

COST OF ALTERNATIVE NURSING HOME CARE STUDY
FOR THE
STATE OF MONTANA

The Montana Department of Health and Environmental Sciences is contracting with JRB Associates, Inc. to conduct a study on the cost of alternative care to nursing homes for the elderly and mentally handicapped. This study is designed to investigate the following topics:

- Estimation of the number of people in Montana who need assistance to support a relative degree of independence short of institutionalized care,
- Determiination of the population distribution among the kinds of alternative care if appropriate funding were available,
- Estimation of the cost of alternative care,
- Analysis of the operational administrative mechanisms utilized in other states for similar programs, and
- Recommend possible uses for vacant nursing home beds.

One major task for this study is a literature review in the field of alternative care and services for the elderly and mentally handicapped. Particular consideration is given to identifying the available alternatives, their unit cost, and their rate of utilization. The unit cost and utilization information will be utilized to estimate volume requirements for each alternative for the State of Montana.

In order to produce estimates of Montana's population that could be expected to use each alternative, face to face household and institution surveys will be conducted with approximately 1500 Montana elderly and/or mentally handicapped citizens. The survey will encompass all five Health Regions in Montana. Survey results will be reported after adjustments to reflect the Montana population.

This study will also investigate operational alternative programs in other states. A report will be prepared on the administrative arrangements utilized, including: administrative staffing levels, number and population served, organizational structure between state and county governments, involvement of the private sector in administration and service delivery, and federal participation in financial arrangements.

The study is expected to be completed in June, 1980. Further information about this study can be obtained by contacting the Project Manager:

Dr. Steven S. Lazarus
Director - Denver Office
JRB Associates, Inc.
40 Denver Technological Center West
7935 East Prentice Avenue
Englewood, CO 80111

(303) 773-6883

SSL:ms

7/79

Appendix J

2. Report # 1: Literature Review

REPORT # 1

LITERATURE REVIEW

COST OF ALTERNATIVE CARE STUDY

Submitted to:

Health Planning and Resources Development Bureau
Montana Department of Health and Environmental Sciences
Helena, Montana

Submitted by:

JRB Associates, Inc.
40 Denver Technological Center West
7935 East Prentice Avenue
Englewood, Colorado 80111

(303) 773-6883

JRB No. 02-800-02-519-10

Report No. JRB-D-79-02

October 10, 1979

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1.0 INTRODUCTION

1.0 INTRODUCTION

The Montana Department of Health and Environmental Sciences, Department of Institutions, and Department of Social and Rehabilitation Services are working on a Task Force to recommend legislative and budget considerations for the 1982-83 biennium regarding appropriate investment of state funds toward the necessary support and care of the elderly and mentally handicapped. Some of the services that are considered reasonable alternatives are: homemaker services, adult day care, home health care, meals-on-wheels, personalized nursing care, and sheltered group homes (personal care homes). It is recognized that other innovative mixes of services have been employed to encourage greater independent living by vulnerable people. What is not known is (1) how many people in Montana need assistance to support a relative degree of independence short of institutionalized care, (2) how the people in need distribute among the kinds of care that might be available if appropriate funding were available, and (3) how much these kinds of care cost.

In June, 1979, the Montana Department of Health and Environmental Sciences contracted with JRB Associates, Inc. to conduct a study on the cost of alternatives to nursing home care for the elderly and mentally handicapped. This report is the first in a series to be prepared as part of that study. The first study report is concerned with a review of the literature on alternatives to nursing home care for the elderly and mentally handicapped. The report is organized into three technical sections:

- An abstract of conclusions from the literature review identifying the alternatives that will be considered in the study,
- An annotated bibliography of technical literature that substantially contributes to the identification of alternatives, their unit cost basis and volume basis, and
- A bibliography of literature reviewed.

This study is being conducted by the Denver Office of JRB Associates, Inc. The literature reviewed for this study was obtained by JRB staff in Denver and McLean, Virginia and the staff of the Librarian Information Services

unit located in the Denver Office of Science Applications, Inc., JRB's parent company. JRB personnel in Denver and McLean participated in preparing the annotated bibliography. This report was prepared by the JRB Denver Office staff.

2.0 CONCLUSIONS FROM THE LITERATURE REVIEW

2.0 CONCLUSIONS FROM THE LITERATURE REVIEW

2.1. ALTERNATIVES THAT WILL BE CONSIDERED IN THE STUDY

The potential study alternatives fall into four categories: home care services, adult day care, congregate living, and personal care homes. There is sufficient published data, data from demonstration projects, and Montana data to estimate the unit service cost for each of these alternatives and the frequency with which services will be required. While one report does estimate the percentage of population over 65 that would need several of these services, in general this data is not available and a survey will be required to relate the incidence of use to the State of Montana and to each planning region.

There is a dearth of data in the literature on alternatives to nursing home care for the mentally handicapped. There is very limited information on personal care homes.

2.2. CONCLUSIONS FROM THE LITERATURE

2.2.1. Conclusions from the Literature on Home Care Programs

There are several studies in the annotated literature review on organized home care programs. Many of these are federally funded demonstration projects. While many of these demonstration projects lack good cost evaluation data at this time, there are several recurrent themes regarding the organization of these programs. Home care programs consist of a variety of services which need to be coordinated through a single agency which arranges for patient intake assessment and coordination of services. Service cost estimates and utilization rates for services can be based upon data supplied by the Wisconsin Community Care Organization project, the Monroe County Long Term Care Program, Triage, and similar projects. The Wisconsin Community Care Organization project is most likely to be directly relevant to Montana since one of the demonstration sites is a rural county and a second is a medium size urban area. Medicaid and Medicare reimbursement rates for Montana will also be utilized in estimating cost for this program. Very

careful attention must be paid to defining the target patient population as one which would likely be placed in a nursing home but for the existence of a home health program. Both the Wisconsin Community Care Organization and the Monroe County Long Term Care Program utilize well defined target population definitions, although each has a different basis. Therefore, cost estimates for this alternative will be based upon the experience of at least two organized home care demonstration projects, with cost data adjusted for the prices of medical care in Montana and inflation (by using the United States CPI-U).

The Wisconsin evaluation project expects to have an analysis relating scores on the Geriatric Functional Rating Scale to the cost of care completed by March, 1980. Since this is the same survey instrument that is recommended for use in Montana and the Wisconsin environment is in many respects similar to Montana, there is the prospect for the program cost estimation for Montana in the final report of this study to be reasonably accurate.

2.2.2. Conclusions from the Literature on Adult Day Care

Three relevant articles were found in the literature on adult day care: Grimaldi (1979), Weissert (1977), and Weissert (1978). These articles give estimates on the frequency of utilization of adult day care services and the cost per day of these service programs. Two different adult day program models are discussed. Cost estimates for adult day care will be based on these articles, two in-depth studies referred to within these articles, and present price levels for this service if it is offered in Montana.

Adult day care is expensive on a per service day basis. Transportation costs and inefficient use of staff contribute to the unexpected high cost for this program. Since patients have to travel to and from the adult day care center and this lessens the activity day length, staff are not generally utilized for a full eight-hour day, yet they must be compensated for a full day's work. The studies also refer to the possibility of lowering adult day care program costs by having larger adult day care programs, perhaps reaching a level of 100 patients per day. This larger patient service activity would spread the administrative and other overhead costs over a larger base. This same efficiency may be achievable when adult day care programs are administered and located in the same facility as a hospital or nursing home.

This option will be explored further in the cost estimating process in the Final Report.

2.2.3. Conclusions from the Literature on Congregate Living

The most useful article in the annotated bibliography on congregate housing is the December 1976 report, Evaluation of the Effectiveness of Congregate Housing for the Elderly, prepared by HUD. This report describes in detail the types of people that apply for congregate housing. Some cost information is contained in the article; however, better estimates of the cost of this alternative to nursing home care are likely to be obtained by current congregate housing prices in Montana.

The HUD report indicates that meals, housekeeping, and on-site activities were not regarded as important features to applicants for this housing, but the availability of medical services was regarded as important in case of emergencies.

2.2.4. Conclusions from Literature Review on Personal Care Homes

The literature review found very little useful information on personal care homes. These homes have historically constituted a small proportion of the beds in nursing care and related homes reported by DHEW. In 1973, personal care homes and domiciliary care homes accounted for 16% of all beds in nursing care and related homes in the United States. This is a decline from 25% reported in 1969. An estimate of the proportion of elderly who would utilize personal care and homemaker services at home or in sheltered living facilities is given in the report, Long-Term Care: Actuarial Cost Estimates.

Current research, federal program direction (both by the administration and Congress), and state initiatives on alternatives to nursing home care generally do not include personal care homes as an option. There is little information available in the literature on which to base a projection of utilization and cost for this alternative. Therefore, unless another basis can be found for these projections, consideration should be given to not including projections of cost and utilization of personal care homes as part of this study.

2.2.5. General Conclusions from the Literature

The annotations for a significant number of articles on the alternatives to nursing home care for the elderly and mentally handicapped are included in Section 3.0 of this report. Although many of the annotated articles do not contribute directly to estimating the costs or utilization of specific alternatives, they have been included for several reasons. Some articles describe operational aspects of projects which are important to defining the characteristics of each alternative. Other articles describe survey instruments that have been utilized to assess patients or project the need for institutionalization. Finally, a large number of the annotations describe studies on the costs of alternatives to nursing home care for the elderly and mentally handicapped; however, the analyses are not directly relevant to this study because: the results are not based on a random sample, the results only apply to large urban areas, the results are based on too small a sample and/or the cost analyses have been done incorrectly.

It is important that Executive and Legislative officials proposing alternatives to nursing home care understand the shortcomings of many of the "studies" that have been conducted in this area. Much of the testimony presented to Congressional Committees on this issue is on the basis of a small number of cases or on the basis of one or two individual cases which site significant cost savings by keeping a specific individual out of a nursing home. However, in order to assess the costs of alternatives to nursing home care, all health related costs for patients treated in the nursing home environment and those treated in the alternative must be included. The Wisconsin Community Care Organization project is taking this approach in its cost analysis (which will be available in March, 1980).

Four of the annotated reviews describe studies that will be useful in providing a frame of reference to validate and compare the estimates from this study. They are: Congressional Budget Office (1977), Frohlich (1971), Palmore (1976), and University of Rochester School of Medicine and Dentistry (1968).

There is very little information in the literature on the cost and utilization of alternatives to nursing home care by the mentally handicapped. Some of the home care projects, including Wisconsin and Monroe County, New York,

include disabled adults in their program. Wisconsin has utilized the Geriatric Functional Rating Scale to predict institutionalization for both elderly and disabled adults. While the predictions for the disabled are less valid, they are useful to the project and have limited validity. The literature review does not provide a valid basis for estimating costs and utilization of alternatives to nursing home care for the mentally handicapped.

2.3. BASIS FOR RELATING COST ESTIMATES TO MONTANA AND A SINGLE POINT IN TIME

To the extent possible, all cost estimates will be related to the cost of providing similar services in Montana in current prices. This information will be sought from the Montana Department of Social and Rehabilitation Services, the Medicare program, and other appropriate agencies. Cost projections based on prior years will be adjusted by utilizing the CPI-U index. The appropriateness of the total index or the medical care component will be reviewed prior to making each adjustment. One base year will be identified for all these projections, probably 1980.

2.4. CONCLUSIONS FROM THE LITERATURE REVIEW ON SURVEY INSTRUMENTS

The literature review identifies two well defined and tested survey instruments used in alternative care programs, OARS (Older Americans Resources and Services) and GFRS (Geriatric Functional Rating Scale). A variety of other instruments have been utilized in individual studies and other instruments have been used in multiple studies that require extensive provider personnel administration. These two instruments can be administered in a relatively short period of time, have been used in multiple studies, and have a well defined structure and analysis. The GFRS takes less time to administer and is the only instrument available which can validly be used to project the probability of institutionalization for a population of elderly (and disabled). The validation is described in the article by Grauer and Birnbom (1975). The Wisconsin Community Care Organization project utilizes both GFRS and OARS for patient intake and evaluation. The Wisconsin evaluation study team is investigating the relationship between treatment costs and GFRS scores. The GFRS can be administered in approximately fifteen minutes and has been tested as a valid prediction instrument. OARS is also a widely

used patient assessment instrument, but is less desirable for use in this study because it takes longer to administer, is usually administered by providers, and has not been validated as a predictor of institutionalization (with the literature reviewed in this report).

2.5. OTHER LITERATURE

The scope of this literature review is wide and the potential sources of information are numerous. In addition, this topic is one that is under continuous study at the national and local levels at this time. Several different tactics have been utilized to identify and obtain the literature in this field. Therefore, it is possible that a relevant study has been omitted from this review, or that by the time this project is completed additional relevant studies will be available. The Final Report of this project will include a summary of additional identified studies on this topic.

3.0 ANNOTATED BIBLIOGRAPHY

Bell, Bill D. "Mobile Medical Care to the Elderly: An Evaluation." The Gerontologist, April 1975, 15(2): 100-103.

The author describes and evaluates a statewide, mobile health care program, aimed at older rural persons in Arkansas, called Multiphasic Examinations to Reduce Chronic Illnesses (MERCI). About 13% of Arkansas' population is over 65; nearly half of them fall below poverty level, and 50% live in rural areas. Medical facilities are not spread evenly throughout the state, and most counties lack a physician. The greatest barriers to health care are, in order, finances, transportation and accessability.

The MERCI project has a converted school bus, funded totally from State and Federal sources, staffed by seven persons. This unit travels to areas at least twenty miles from a physician to screen residents over 60 for specific chronic illnesses. In its first six months of operation (September 1973 - March 1974) the unit screened 2,738 persons (95.3% over 60, 42.7% men, 66.8% white and 76.4% with annual incomes below $3,000). Test results showed high incidences of hypertension (31%), heart trouble (22%) and eye problems (17%). Because of the manner of media exposure chosen (newspapers, radios, posters, etc.), it is felt that blacks were not as aware of the availability of MERCI as whites. The author felt that the weakest aspect of MERCI was the referral process: patients were relied upon to consult a physician if told to. Evaluation of the referral system is not made.

The cost per patient was $16, deemed high by the author. The acronym "MERCI" was also thought to paint a negative picture in the public's eye. But in general, Bell stated, " . . . an adjunct medical system such as this contributes significantly to the . . health . . of an elderly population."

Bell, William G. "Community Care for the Elderly: An Alternative to Institutionalization." The Gerontologist, Autumn, 1973, Part I, 13: 349-354.

Prepared at the request of the Florida Dept. of Health and Rehabilitative Services, this study focused on Medicaid-supported elderly admittees to all licensed nursing homes in Hillsborough County during September, 1970, and a comparable group of functionally impaired elderly residing at home drawing Old Age Assistance (OAA). These groups were chosen due to their associated high costs, medical vulnerability, and lack of adequate spokespeople.

The author first reviewed two policy issues related to care for the elderly: economic (as many as 30% of the institutionalized elderly were judged by a panel of "experts" to be inappropriately placed and there was a disproportionate percentage of OAA recipients in nursing homes. Therefore, continued allocation of resources for sustained institutional expansion without consideration of alternate measures is "subject to question") and personal preference (85% of the sampled low income elderly preferred to live at home whether or not living there when asked; the literature suggests negative effects of nursing home life).

He then proposes a community care program, incorporating in a single public agency health maintenance, help with housekeeping and shopping, mobile meals, transportation to essential services and counseling (crisis intervention) advocacy. These components were selected because of indications for such in the literature; their necessity for normal daily living; low costs when compared to nursing home placement; urban availability, or at least ease in establishment of these services; and potential of the program to free a family member to join or return to the workforce.

Berg, Robert, et al. "Assessing the Health Care Needs of the Aged," Health Services Research, Spring 1970, 5(1): 36-59.

During the early 1960's the author directed personal interviews of institutionalized and non-institutionalized elderly in Monroe County, New York. Over a six month period, a physician/public health nurse team conducted interviews of 349 elderly individuals of all income levels, selected at random. The survey was designed to assess the respondent's need for either mental or physical care or both. The amounts of medical and mental care supervision required by the respondents were then tabulated to yield an estimate of their needs for various levels of care. Berg concluded that 6.7 percent of the elderly population would be optimally served by a public home health nursing agency.

Branch, Laurence G. Understanding the Health and Social Service Needs of People Over 65. Center for Survey Research, University of Massachusetts, 1977.

The author surveyed the health care needs of the non-instutionalized elderly and disabled in the State of Massachusetts.

The sampling frame consisted of 2,000 Massachusetts households comprised of high users of medical services, the elderly and the disabled. Between November, 1974 and February, 1975, 1,625 elderly and 386 disabled persons were interviewed about their needs for medical, social and homemaker services. Follow-up interviews were conducted fifteen months later with only the elderly, to determine the extent to which these needs had been met. Branch reports his results in four categories ranging from "need currently met with no apparent problem," to "need currently unmet with a current problem."

Branch found that seven percent of the sampled elderly had unmet needs for transportation, four percent for housekeeping, four percent for food shopping, .5 percent for food preparation, six percent for socializing and three percent for personal care assistance.

Brickner, Philip W. Home Health Care for the Aged: How to Help Older People Stay in Their Own Homes and Out of Institutions. New York: Appleton-Century-Crofts, 1978.

This book describes a New York City hospital based alternative to nursing home care program. The descriptive materials include: how to establish a program, the role of each professional provider in the alternative home care program, and a discussion of the financial basis for a program including how to fund a program. Time study analyses were conducted to provide the cost estimates of the alternative care program. The author correctly points out inappropriate placement in nursing homes adds further to the cost for nursing home care which is usually ignored in most cost comparisons (and that overbuilding of nursing homes for profit in some parts of the country has resulted in a concentrated effort to fill the unneeded beds).

The nursing home cost estimates reported for comparison purposes in this study are based upon physician estimates of the number of nursing hours required for 23 selected program patients and then extrapolated from a regression analysis of 23 nursing homes. They are not based on a matched control group. The project program costs are based upon 23 of 29 patients. It was not indicated in the report if these patients were selected at random, but 6 were rejected by the physician panel for consideration of the cost comparison since they were not candidates for nursing home care. It is curious that the author indicates a concern for inappropriate placement of nursing home patients which would further inflate the cost per patient for nursing home care, while not considering the same factor in the hospital based home health care program. In any case, the cost comparisons are based upon estimation techniques rather than controlled comparisons, the number of observations is extremely small and only nursing home and alternative care program costs are included (other medical costs are not included).

Brickner, Philip W., James F. Janeski, Sister Teresita Duque. "Hospital Home Health Care Program Aids Isolated Homebound Elderly." Hospitals, November 1, 1976, 50: 117-122.

In January 1973, the Chelsea Village Program was started to meet the health case needs of the isolated, homebound elderly living in the Chelsea and Greenwich Village areas surrounding St. Vincent's Hospital. This area in Manhattan is one of the few remaining "melting pot" areas of the city, and it houses roughly 175,000 people. Approximately 14 percent, or 24,500 individuals, are over age 65, as compared with 10 percent nationally. The number of individuals who need home health services is estimated to be about 3,000.

During the first three and one-half years that the program has been in operation, 414 persons were referred to the program, and 2,900 home visits were made. There were 262 women and 152 men participating in the program. Eight percent of the patients are under age 60. These younger people suffer from mental retardation or chronic neurological or psychiatric disorders.

The present reimbursement rate for nursing homes in New York City averages $14,000 per year. Home health care for semi-ambulatory patients is about half as expensive as the cost of nursing home care. A conservative estimate indicates that during a 12-month period of the program, 70 patients were maintained at home who otherwise would be nursing home candidates. A savings of approximately $500,000 is therefore generated by this one program alone.

Brickner, Philip W., et al. "The Homebound Aged: A Medically Unreached Group," Annals of Internal Medicine, January 1975, 82(1): 1-6.

The Chelsea Village Program began in January 1973 to meet the health-assistance needs of aged, homebound, isolated residents of the Chelsea and Greenwich Village areas of Manhattan surrounding St. Vincent's Hospital. The aims of the program are to keep patients in their community, out of institutions, in adequate housing, in the best possible state of health, and at the maximum level of independence. Local organizations and community residents serve as case-finders; home delivery of a broad range of services is carried out by St. Vincent physicians, a nurse, social workers, a driver (with van) and a coordinator. The program coordinates with Visiting Nurses, meals-on-wheels, a homemaker assistance agency and others to supply CVP patients with extra services. In the first 16 months of operation, 200 referrals and 620 visits were made. The average age of CVP patients was 80; 40% had medical disorders, 24% bone/joint problems, 17% psychiatric disorders and 11% neurological diseases. Three-fourths of the referrals were from community agencies, one-fourth from St. Vincent's. Nineteen patients have improved to the extent that they are no longer housebound; 104 remain stabilized under CVP care at home (of these, Brickner et al estimate that 85 could have required institutionalization were it not for the program). Program problems include poor case finding, lack of cooperation by other physicians who may be treating the patient, lack of volunteers, and lack of money for adequate staffing.

Annual cost of the program is only $35,000, due to the fact that the professional staff volunteers its time, and private agencies fund the non-professional salaries and van expenses. The authors estimate (with some reservations) savings to the community at $340,000 per year.

Benefits of the program, other than financial as already mentioned, are an enhanced relationship between hospital and community, and assistance to a truly medically-unreached group of people.

Brody, Stanley J. "Comprehensive Health Care for the Elderly: An Analysis," The Gerontologist, Winter 1973, 13: 412-417.

Presented originally as a paper to the Gerontological Society in 1971, this article begins with a broad overview of the traditional medical emphasis on the quantity rather than the quality of life. Brody asserts that a truly comprehensive system of health care must take into account a broader view of the patient and his needs, and thus must move from the usual hospital focus to a community base. In particular, the elderly, with high rates of chronic illness (81%), mental impairment (as high as 25%), and difficulty in performing such simple tasks as walking down stairs (30%), require a care delivery system that provides not only medical and health resources, but also support services that would enable them to utilize those resources (e.g., transportation). Brody outlines three types of "insults" to the aging process: mental, physical and environmental (i.e., fear of assault, forced to live in "bad" neighborhoods due to low income, lack of information, etc.). He mentions five "health-social" services which are essential to the continuum of care for the aged: personal hygiene, supportive or extended medical care, maintenance (including housekeeping and meals), counseling and linkages (education, outreach, referral, etc.).

Brody goes on to assess Medicare coverage as well as some of the sixteen proposed programs before Congress at the time, regarding their handling of health-social services. Medicare would not cover more than 100 incidents of home health care, and even those must be provided by an agency that meets several stringent criteria. Of the 20 million subscribers in 1969, less than 3% were reimbursed for home health services. Paradoxically, unless the patient is ill enough to require institutionalization, he cannot receive the identical services in his own home. Under the Javits proposal, contracts with "comprehensive health services systems" are authorized. The Nixon, HIAA, and Long proposals did not extend coverage beyond Medicare standards. The AMA proposed an even stricter bill, equating health care with medical and in-patient care only. Somewhat more liberal was the Kennedy-Griffith proposal, which included transportation services, physiotherapy, nutrition, social work and health education when performed by Health Security Board certified agencies. The author found the best plan to be that suggested by Ameriplan, which would assure home health care coverage, including part-time nursing care, home health aides, social service, and speech, physical, or occupational therapy.

The author concludes that if the current disease-oriented approach in the U.S. continues, the needs of the elderly will not be met, and legislation must reflect these needs by way of a comprehensive health care system.

Burton, Richard M., William W. Damon, and David C. Dellinger. "Patient States and the Technology Matrix," Interfaces, August 1975, 5(4): 43-53.

This article describes the mathematical model which can be used to predict patient status, treatment mode, and cost over time. The paper is directed to formulate a mathematical model and show examples of the type of data that would be utilized. The data base illustrated is based upon OARS information gathered at Duke University. The paper is directed to describing the model formulation, rather than illustrating valid data or predictions.

A substantial amount of information is required to utilize this model and the authors have not applied it to any specific cases.

Burton, Richard M., et al. "Policy Analysis in Health Systems Planning: An Application of Operations Research to the Problem of Caring for the Elderly," G.S.B.A. Working Paper No. 117, Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina, May 1975.

The authors describe a methodological approach of developing a mathematical model to analyze the costs and utilization of alternative treatment modes for the elderly. They describe a 32-patient state classification scheme and 25 major alternative treatment modes. No empirical analysis is reported. Instead, the authors emphasize the importance of a mathematical model structure in helping to understand the components of the problem of predicting costs and care strategies for the elderly. They also note that for some service packages, production is less costly in nursing homes than in non-institutional settings; however, they do not describe which service packages fall into this category.

They also describe the results of a survey of a sample of 1,000 persons among the 10,000 elderly persons in Durham County, North Carolina. Sixty percent of the elderly population were found to have no impairments, while 12% were found to have more than two impairments.

Colt, Avery M., et al. "Home Health Care is Good Economics," Nursing Outlook, October 1977, 25(10): 632-636.

This study is based on two populations in Rhode Island, one consisting of 50 records selected at random from a population of elderly who have exhausted their Medicare benefits and are in a special home health care program as an alternative to insitutionalization, and a second group of 50 from a Rhode Island low-income group with a home health care program not specifically designed to prevent institutionalization. Two significant criticisms of the study are that of the 50 randomly selected from the first group two records were dropped from further consideration although the reason for this was not specified. (Dropping the two highest utilizers of services from a sample of 50 can drastically effect the cost results of the study; also, the second (comparison) group was not a group matched for demographic and other characteristics.)

Average cost per patient enrolled day was reported to be $5.15 in the first group (which only includes the home maintenance service cost of care). An enrollment day is different from a service day.

In the cost comparison section of the paper, which compares home maintenance costs to cost of institutional facilities, the medical care component of the Consumer Price Index was used to make the two-year adjustment. There is a statement which says that the home maintenance program saved Medicare and State Medical Assistance programs $855 in insitutional care charges per enrollee in the total sample year, but this statement cannot be tracked from the data presented in the paper. In addition, when the savings is multiplied by $100, the authors indicate that the saving totals out to $8,500 per year which indicates that either this number is off by a factor of 10, or the $855 number is ten times too high. The cost comparisons do not include any information about other government supported health care services received by the patients in either population, including physician, pharmacy, hospitalization, and other medical services. Although the authors conclude that "costs of home maintenance were significantly lower than costs of alternate institutionalization in both study samples," this conclusion is not supported by the data presented in this paper, and does not take into account all of the medical and public and private support costs involved by both populations.

Comptroller General of the United States, HRD-78-19, Report to the Congress: Home Health -- The Need for a National Policy to Better Provide for the Elderly, December 30, 1977.

This report is the basis for some of the GAO testimony for Congressional Committees on the cost of long-term care alternatives by changing Medicare and Medicaid. The report indicates that about 60% of the elderly who are extremely impaired live outside of institutions. These people currently receive a wide variety of in-home services such as personal care, meal preparation, nursing care, homemaker service, and continuous supervision. Other services they receive are transportation, housing, social and recreational. These are generally called "home services". Many of these services are provided by family and friends and, in general, the cost of non-institutional care for the elderly is borne in greater proportion by private funds and family services than by public financed services.

The GAO has been conducting a continuing study in Cleveland, Ohio of 1,609 individuals 65 years and older who receive services from 118 service agencies. OARS is one of the survey instruments that has been administered to this population. The study recommends that Congress consider focusing its job creation program for assisting the sick and elderly on those older people who live alone and are without family support.

Estimates are reported for the cost of eliminating various constraints on the Medicare program as follows:

• Limits on number of visits under Parts A and B	$ 12.5 million
• Skilled care requirement under Parts A and B	$1,250.0 million
• Prior hospitalization requirement under Part A	$ 12.5 million
• Homebound requirement under Parts A and B	$ 92.5 million
• Adding homemaker/chore services	$ 75.0 million

These limitations cannot be totaled since there are interactions among them.

The study also cites the difficulties in coordinating public home services. The principal federal programs providing home services are Titles XVIII, XIX, and XX of the Social Security Act and Titles III and VII of the Older Americans Act. These programs cover different services and have different eligibility criteria. The study concludes that home health care and other related home-delivered services for the elderly are not being effectively coordinated. Services are available through so many different programs that effective coordination delivery of home health and other in-home services seems close to impossible. The study recommends that HEW should promote the establishment of a comprehensive single entry system by which individuals are assessed as to their needs, prior to placement in a program.

Congressional Budget Office, U.S. Congress, Long-Term Care: Actuarial Cost Estimates, August 1977.

This study estimates the costs of three options for long-term care for the elderly and disabled: modifying existing programs that restrict the supply of non-institutional services under the current system; long-term care insurance that would eliminate financial needs as a basis for eligibility and replace much private spending with federal spending; and comprehensive long-term care grant to funnel funds through a single agency that would be responsible for providing services to needy individuals. The estimates for all three programs indicate that the implementation of any of them would be bound in the short run by the available supply of resources since current need exceeds supply. Expansion of services and response to new demand may be restrained by the capacity of present organizations for several years because of the following:

- Shortage of experienced supervisory and skilled personnel;
- Shortage of available capital;
- Delays in construction or conversion of facilities;
- Possible reluctance of some providers to grow rapidly; and
- The time required for organizations not currently involved in providing long-term care services to obtain the necessary certifications and licenses and assemble personnel.

Based upon studies in Monroe County, New York and Minneapolis, estimates were prepared on the percentage of the population over age 65 that would need the following services: skilled nursing facilities; intermediate care facilities; personal care homes and sheltered living facilities; intensive nursing at home or in sheltered living facilities; and intermediate nursing, personal care and homemaker services at home or in sheltered living facilities. All of these estimates are based in terms of fiscal 1976, have a range of percentage with a spread of two to five percent, and are cumulative percentages by level of care. For all care listed, between 16.5% and 21.5% of the elderly have some need. The ranges are at best a gross approximation of the proportion of persons who would qualify for public programs that funded all necessary services. Although there are limitations, the data are adequate to demonstrate that, with the exception of institutional nursing facilities, far more persons would qualify for benefits than there are facilities and personnel to provide them.

This study also estimates reimbursements per day for skilled nursing facilities, intermediate care facilities, and facilities for the mentally retarded for the years 1973 through 1976.

Davis, John W. and Marilyn J. Gibbin. "An Areawide Examination of Nursing Home Use, Misuse and Nonuse," American Journal of Public Health, June, 1971, 61(6): 1146-1155.

Davis and Gibbin studied 3,314 hospitalized elderly, nursing home patients, state mental hospital patients over 65, and other individuals who were in need of nursing home care but were not so placed, in a 6-county area of Western New York between 1967 and 1969. Data were collected by social workers and public health nurses, and appropriateness of placement was judged by one or two (if the first judged "inappropriate") physicians.

Current Placement	Needed Placement					
	Total	N.H.	General Hospital	Mental Hospital	Intermediate Care Facility	Other
Nursing Home	1,621	1,186 (73.2)	5	1	276	153
General Hospital	465	101	268 (57.6)	2	68	26
Mental Hospital	757	117	7	184 (24.3)	216	233
Home for Well Aged	50	11	0	0	38 (76.0)	1
Own Home	421	92	3	0	266	60 (14.3)
TOTAL	3,314	1,507	283	187	864	473

When examining the characteristics of the 1,507 needing nursing home placement, the authors found that females and older people were more often placed correctly; a higher percentage of people requiring assistance in ambulation than those who could walk independently were not in nursing homes; a far higher proportion of married persons needing nursing home care were not receiving it despite any differences in functional status; and many other indications. The authors conclude that demographic characteristics are better predictors of nursing home placement than functional status.

Possible reasons for these problems are discussed: unavailability of nursing home beds or other resources; and personal preferences of patient, family or nursing home administrator.

The implications of the study are that administrators must be willing to discharge a group of more "minimal care" cases and admit a group with greater care needs -- planners should take heed. The discharged group needs places to go, and the authors again urge planners to work appropriately towards establishing appropriate settings, such as intermediate care facilities.

Doherty, Neville and Barbara Hicks. "Cost-Effectiveness Analysis and Alternative Health Care Programs for the Elderly," (Presented at the Joint National Meeting, Operations Research Society of America and The Institute of Management Sciences, Miami Beach, Florida, November 3-5, 1976.).

The authors describe a theoretical framework for measuring effectiveness and costs of programs which are alternatives to nursing home care. Three measurement criteria are referred to: ADL (Activities of Daily Living), MSQ (Mental Status Quotient), and IADL (Instrumental Activities of Daily Living). These can be related to physical, mental, and social functioning.

Illustrations of tabular analyses are presented, but no real data is utilized. Doherty is the principal investigator for the evaluation of the Triage project in Connecticut.

Donahue, Wilma T., Marie McGuire Thompson, and D. J. Curren, Editors. Congregate Housing for Older People: An Urgent Need, a Growing Demand. Washington, D.C.: U.S. Department of Health, Education and Welfare, Office of Human Development, Administration on Aging, DHEW Publication No. (OHD) 77-20284, 1977.

This book contains selected papers from the First National Conference on Congregate Housing for Older People, conducted by the International Center for Social Gerontology which was held on November 11-12, 1975. The Conference developed a working definition of congregate housing: an assisted independent group living environment that offers the elderly who are functionally impaired or socially deprived, but otherwise in good health, the residential accommodations and support services they need to maintain or return to a semi-independent lifestyle and prevent premature or unnecessary institutionalization as they grow older.

Three papers in this publication are significant. The paper by Louis Glewicks, "An Architectural Program" (pages 73-86) describes in specific terms some of the considerations for designing and allocating space to a congregate living facility. The paper by George Thomas Beall, "Financing the Services", summarizes many of the financing programs available at the federal, state, and local levels to support residents of congregate living facilities. Finally, Penelope Hummell Pepe has prepared "An Annotated Bibliography on Congregate Housing".

This report contains no data except for some U.S. demographic information. The annotated bibliography may be the most useful chapter.

Evaluation of the Effectiveness of Congregate Housing for the Elderly, Washington, D.C.: U.S. Department of Housing and Urban Development, Publication Number HUD-PDR198-2, December 1976.

Congregate housing is characterized by: age-segregation, an integrated housing and services package, and a non-institutional environment. This study is based upon 29 congregate living sites throughout the United States and a survey of 25 residents and 10 applicants at 19 of these sites (for a total of 469 respondents). Most congregate living facilities were found to be in urban areas. There is an apparent consistency among congregate housing policies and operations: e.g., the physical design of facilities expresses the stated management policy in most cases. Common features in sites where management assumed a high degree of independence among residents were: kitchen facilities in most units, less common space per resident, and a high level of access to community services.

Approximately 90% of all residents are over the age of 70 and 63% were widowed females. Approximately 57% of all applicants are over 70 and 65% were widowed females. About 4% of residents and 13% of all applicants lived with family (children) prior to moving to congregate housing. Recently widowed homeowners sought out congregate housing, whereas widowed apartment renters did not seem to seek out this alternative immediately after the spouse's death.

Low income groups seemed to regard congregate housing as shelter, in contrast to high income groups which sought congregate housing to be close to family, for favorable climate, because of difficulty in maintaining their own home, and for health reasons. Meals, housekeeping, and on-site activities were not regarded as important features, but the availability of medical services was regarded as important in case of emergencies. As health declines, dependence on special features significantly increases; e.g., barrier-free design, ramps, handrails, tactile aids, etc. Sixty-six percent of the residents found the availability of medical services useful.

The following cost data was determined from the survey:

COST ELEMENT	LOW	HIGH
Total development and construction cost per square foot	$ 10.08	$ 45.92
Total development and construction cost per housing unit (varies by square foot per unit)	$6,236.00	$29,706.00
Annual operating costs per unit (not per resident)	$ 723.00	$11,573.00
Costs per meals served	$ 0.71	$ 2.04
Annual meals services per resident	$ 130.00	$ 339.00
Annual housekeeping per unit	$ 33.00	$ 386.00

Frohlich, Philip. "Who Are the Disabled in Institutions?," Social Security Bulletin, October 1971, 34(10): 3-9.

Table 6 in this report describes the reasons for institutionalization of institutionalized adults aged 18 to 64 for the Fall, 1967 by type of institution. This report deals exclusively with individuals under the age of 65.

For the 282,000 individuals reporting, the reasons given for institutionalization were the following:

-- Need permanent care	37.6%
-- Had to be watched and looked after more carefully	37.6%
-- Needed medical nursing care	34.0%
-- Too hard to handle at home	28.5%
-- Need special training	15.3%
-- No one to look after at home	12.1%
-- Too costly at home	7.0%
-- Other and not reported	14.2%

This data would indicate that many of the institutionalized adults under the age of 65 are placed in an institution for other than medical reasons.

Grauer, H. and F. Birnbom. "A Geriatric Functional Rating Scale to Determine the Need for Institutional Care," Journal of the American Geriatrics Society, October 1975, XXIII(10): 472-476.

This study was carried out to validate a rating scale which could serve as a guide in determining the need for institutional care. The scale assesses the subject's physical and mental disability, balanced against his ability to function and the support available from relatives and community resources. Cut-off points were tested by the use of an 18-month follow-up interval. Initially, 130 aged men and women from three different settings were rated. At the time of follow-up eighteen months later, 83 percent of the subjects who had obtained an initial score indicative of their inability to function in the community were either dead or in an institution. In contrast, 90 percent of those who obtained an initial score indicating that they were able to continue in the community, were not in an institution at the time of follow-up. The rating scale can be used not only to help decide the need for institutional care, but also to help determine the most suitable setting for the patient if placement is necessary.

Greenberg, Jay. Supportive Services: 1974 Status and Needs Survey of the Elderly, Staff paper, (Minnesota), September 1974.

In this paper the author discusses the results of the 1974 Status and Needs Survey of the Elderly in the State of Minnesota. The survey consisted of 1,500 completed interviews using statewide random cluster samples which were stratified by development regions.

Greenberg estimated that about two percent of the non-institutionalized elderly population needed some skilled nursing care. He based this estimate on an average of data showing that one percent of the elderly could not bathe themselves and that three percent were unable to walk around the house. The types of services that these elderly would require would be two hours weekly of skilled nursing supervision, ten hours of personal care services and homemaker and chore services amounting to about seven hours weekly.

In addition, Greenberg estimated that another five percent of the non-institutionalized elderly population required four hours of such personal care services as dressing and bathing and six hours of home maintenance and chore services. He estimated that an additional nine percent of the elderly required about five hours of housekeeping and chore services weekly and finally, another fifteen percent could have used chore services amounting to one half hour a week.

Griffith, John R. "A Home Care Program for a Small Community," Hospitals, Journal of the American Hospital Association, June 16, 1962, 36: 58-65, 140.

The author describes how a 75-bed hospital and a county health department in Albion, Michigan, with funds from the Kellogg Foundation, combined efforts in an experimental program to provide home health care services to any person needing assitance, whether short- or long-term. Higher than average hospital utilization rates and a shortage of long-term care facilities in the area, combined with a desire to reduce patient costs, prompted the establishment of the program.

In the author's opinion, success was based on the broad policies of patient eligibility and on the cooperation of the County Health Department. The program was based at Sheldon Memorial Hospital, had a Policy Committee, and a staff consisting of a medical director, secretary, occupational therapist, dietitian and truck driver. Nurses from the health department provided nursing care. Hospital patients were screened before discharge for possible inclusion in the program. In the home, most minimal care was available, as well as laboratory testing when necessary, and transportation to the hospital was provided for x-rays, etc. Because the program could not utilize nor support a full time social worker, arrangements were made for consultations with one at the state or county health department.

During the first year, 114 patients were "admitted" to the program, using 5700 days of service; over half of them were 65 and older. Referrals came from hospitals, nursing homes and families. The staff even began rendering services in nursing homes when their specialties were unavailable there (for example, OT). Use of the program seemed uniformly distributed across physicians and geographic areas of patient residence. Most patients had chronic and/or multiple illnesses. The first year, costs totalled $27,300 (most spent on nursing salaries and clerical costs) and average cost per day was $4 per patient, competitive at least with much long-term institutional care in Michigan (averaging at least $10 per day). Unfortunately, collections were poor: third party payers were reluctant to participate, and although Blue Cross was willing to cover costs, only 18% of program patients had Blue Cross coverage. Even with total cooperation of third parties, welfare agencies, and patients, 20% of total charges are expected to remain unpaid. In the future, emphasis will be placed on further reduction of costs, gaining cooperation of funding sources, and analyzing the program's impact on the need for institutional facilities.

Grimaldi, Paul L. "The Costs of Adult Day Care and Nursing Home Care: A Dissenting View," Inquiry, Summer 1979, 16: 162-165.

This paper discusses the cost analysis of the paper by Weissert (March 1978).

This author argues that Weissert has both overstated the cost per day of nursing home care and understated the cost of adult day care programs. The criticisms basically deal with the assumptions made by the first author in estimating various cost data and are not defended by empirical analysis. One of the strongest arguments made deals with the fact that a significant percentage of Medicaid recipients are reported to stay in nursing facilities less than 181 days, thereby arguing against Weissert's assumption on cost which projects the nursing home population to be institutionalized for a whole year when comparing annual costs. There is, however, some question as to how length of stay data is reported for long term care institutions, and that the Medicaid utilization reports may in fact never record more than 365 days as a length of stay. Grimaldi seems to ignore this possibility, although his point is well taken.

He correctly identifies some of the limitations utilized in Weissert's estimation process of adult day care, but also seems to argue that if adult day careprograms are more efficient and serve a larger number of people consistently, their costs will decrease significantly and thus make them a low cost alternative. He also correctly identifies several significant federal and state financial programs that adult day care patients would participate in and nursing home patients would not, thereby again impacting the total cost analysis. Finally, he points out that there may be significant costs of regulating an adult day care program, both in terms of the richness of services delivered and the patient population served. Both of these, if unconstrained, potentially add significantly to the cost of the adult day care program when compared to nursing home care.

Hammond, John. "Home Health Care Cost Effectiveness: An Overview of the Literature," Public Health Reports, July-August, 1979, 94(4): 305-311.

This article describes several studies which investigate home health care as an alternative to hospitalization or nursing home care. The author concludes that the evidence from the studies summarized suggests that from the perspective of third party payors, home care is less expensive than extended hospitalization. He also notes that the limited number of articles available for review indicates caution in drawing similar conclusions regarding the effect of home care on unnecessary hospital admissions. From available information, the costs of home health services for patients requiring the same level of care are roughly equivalant to the costs of nursing home care.

The article contains a review of fourteen hospital-home care studies, none of which are directed to the elderly or mentally handicapped. Most of the studies involve Blue Cross subscribers, less than the age of 65.

Four nursing home--home health studies are described. Only one of these, the project by Brickner in New York City has a large enough sample size to draw any conclusions. Two hundred twenty-two patients participated in this study, but the cost data is incomplete.

The author describes a four-volume set of reports entitled "Applied Research in Home Health Services" which describes several federally funded demonstration projects in home health care. These four volumes are available from National Technical Information Service.

Kastenbaum, Robert and Sandra E. Candy. "The 4% Fallacy: A Methodological and Empirical Critique of Extended Care Facility Population Statistics," International Journal of Aging and Human Development, 1973, 4(1): 15-21.

Much use has been made of population statistics which indicate that only 4% of those over 65 are in nursing homes and other extended care facilities (ECF). These data are misleading, however, for they are cross-sectional and seriously underestimate the probability of a person coming to an ECF sooner or later. Two small empirical studies are reported using, respectively, published obituary notices and death certificates for the metropolitan Detroit area during 1971. It was found that a minimum of 20% of all men and women over 65 who died in the study year were residents of a nursing home, and 24% were residents of one or another kind of ECF. Clearly, more people died in ECFs than are usually thought to be there in the first place. Discussion focuses upon the magnitude of the terminal care problem and the need to recognize the full scope of ECF difficulties which have often been underestimated because of careless use of the population data.

The obituary notice study is based upon the identification of 1,184 deaths and the death certificate study is based on an over 65 population of 2,234.

Kinoy, Susan K. "Home Health Services for the Elderly," Nursing Outlook, September 1969, 17(9): 59-62.

This paper defines the terms homemaker, home health aide, and housekeeper. Homemakers are mature persons usually working under the supervision of a social worker and trained in care of the aged and chronically ill, home management, safety, household services, and escorting duties. A home health aide is part of the medical team directed by a physician and supervised by a registered nurse, giving nursing care in the home. The home health aide gives personal care such as helping the patient with toileting, ambulating, transferring from bed to chair, and doing some household tasks essential to the patient. A housekeeper is a person who performs home maintenance chores, such as housecleaning, laundry, cooking, and shopping.

Kobrzycki, Paula. "Dying with Dignity at Home," American Journal of Nursing, August 1975, 75(8): 1312-1313.

The author, head nurse of a surgical unit, describes her experiences with a hospitalized 22-year old colon cancer victim who, after accepting his inevitable death, chose to die at home with his family nearby. Despite his need for complicated care, his wife and mother both learned to give injections, start IVs and perform other important care tasks. A public health nurse visited him daily and a physician was always available if need be. Because of the openness and goal-oriented attitude of the young man and his relatives, everyone was more at ease in dealing with the situation. He died two weeks after discharge, but the family not only thanked the nurse for making his death easier, but called it "a beautiful experience".

Kovar, Mary Grace. "Health of the Elderly and Use of Health Services," Public Health Reports, January-February 1977, 92(1): 9-19.

This article presents statistics on the elderly in the United States and their use of health services. Patterns extracted from 1973-1975 data are compared with trends of previous years. A few demographic projections are postulated up to the year 2030. The data basically reflects a growing proportion of elderly in the United States and their consequent increased use of short-stay and long-term care institutions. Use of outpatient home health and psychiatric care facilities by the elderly, is increasing at a much slower rate, however. There are no good estimates of the number of elderly served by home health alternative programs, nor of the number who might benefit.

Lang, Sydney L., and Margaret T. Ritchie. "'Home' for Aged," New York State Journal of Medicine, June 15, 1973: 1698-99.

The authors, members of utilization review committees at a hospital and a nursing home, point out their concerns (both economic and social) that more home-oriented health services are needed by the elderly community. Utilization review can determine the proper level of care for an elderly patient, but this assessment is worthless if that level is unavailable. Lang and Ritchie feel that the ultimate goal of medical management is the maintenance of elderly persons in the home or home community, and to this end, propose an expansive home health care program. This program would include: social services, home health aides and housekeeper/food services. A major component of the system would be volunteers who would each assume responsibility for an elderly person needing help. Comparative economics of alternative forms of care for the aged are presented below:

In-hospital	$100 daily
Extended Care/N.H.	50
Health Related Facility	25
Foster Home	10
Home	5

(Sources for cost estimates are not documented.)

LaVor, Judith. "Excerpts from 'Long Term Care: A Challenge to Service Systems,'" Office of the Assistant Secretary for Planning and Evaluation Department of Health, Education, and Welfare, April 1977.

This paper describes several of the federal and state regulatory and reimbursement barriers to structuring alternatives to nursing homes care. It discusses several possible organizational structures for basing community care programs. Potential state and local roles are identified. The author discusses several specific changes which might be entertained in regulation and reimbursement at the state and federal level in order to support alternative community care programs. No statistical or economic analyses are presented.

LaVor, Judith and Marie Callender. "Home Health Cost Effectiveness: What Are We Measuring?" Medical Care, October 1976, XIV(10): 866-872 .

Because of the long debate over definitions of home health care, this paper attempts to establish a conceptual framework for various types of this care, including cost effectiveness measures. The two major goals of home care are to keep people in their normal environments and to aid people in recovering after an institutional stay; most home health agencies attempt to accommodate both concepts. The authors define the three major levels of care as: 1) intensive: provision in the home of a complex of services, or one service frequently rendered (third parties normally cover only this type); 2) basic or maintenance: homemakers, transportation, meals-on-wheels, etc., (seen by third parties as increasing overall costs -- not health services); 3) intermediate: in-between the other two; it is very vaguely defined, but seen as a "fertile area for further exploration." The intensive level of care is appropriate to shorten institutional stays.

Home care has long been considered cheaper than institutional services, but the authors point out the incomparability of data, especially on costs (the former does not take into account room, board and personal care expenses). Information has not generally been collected for research purposes. LaVor and Callender suggest that standardized cost accounting systems, patient data on a per-diem or per-diagnosis basis, equally defined cost elements and comparable patient characteristics are necessary before cost comparisons and generalizations can be made. They caution that population characteristics are not often taken into account, such as comparison of an urban program with a rural one, or a program serving middle-class versus one serving the isolated poor. On top of this, the term "institution" is used broadly, without differences in types of institutions laid out. Their conclusion is that the greater the individual's impairment, the greater the cost of care; and intensive home care may be costly compared to nursing home placement, but not so expensive when compared to hospitalization.

After a review of Federal expenditures in the home health area, (these have not exceeded 1.1% of either Medicare of Medicaid's budget between 1969 and 1973) the authors state their opinion that fears of any large fiscal impact are totally unwarranted even with increased utilization, broadened eligibility criteria and an expanded provider network.

Leonard, Lois E. and Ann M. Kelly. "The Development of a Community-Based Program for Evaluating the Impaired Older Adult," The Gerontologist, April 1975, 15(2): 114-118.

A mental health program designed to evaluate the impaired older citizen within his own home is reported by the Bureau of Patient Care (County Health Department) in Baltimore. Patients who are being considered for placement in a state mental hospital are assessed by a physician and social worker team who determine the patient's level of functioning with a goal of identifying available strengths and appropriate resources to mobilize for his care. A close relationship with other services for the elderly (such as a newly developed Geriatric Clinic) along with an educational approach for family and patient have resulted in more appropriate placement for the older adult manifesting behavioral problems. In fact, in a review of the 465 persons screened by the "Geriatric Evaluation Service", the authors found that 47% remained in their homes, and only 21% did indeed enter psychiatric facilities. The typical patient seen was white, lower-middle class, had a local physician and a concerned family which had contacted at least one resource before the Bureau. As the program grew, more and more referrals came from clergy, family and other community agencies. Three case studies of "successes" were presented as reinforcement of the benefits of this intervention. The authors conclude with several considerations which emerged through program experiences: primary concern with safe-guarding the patient's civil liberties, importance of health professionals in understanding the elderly patient, and education of those who are involved in planning for the elderly.

Libow, Leslie S. "A Public Hospital-Based Geriatric 'Community Care System'," The Gerontologist, August 1974, 14: 289-290.

Dr. Libow describes a comprehensive health care system for the elderly in New York, and urges other community hospitals (or long-term facilities) to "lead in the formation" of similar programs. The essential components of the system are: Visiting Nurse service, physician home visits by the Home Care Division of the hospital, a geriatric convalescent unit in the hospital for the "marginally compensated" elderly patient, a geriatric health maintenance and diagnostic clinic and collaboration between these services and the local proprietary community nursing home. The system was integrated by the community hospital, and because all, or most, of the services were already available (and would be in most areas), costs were low. Libow finds this a viable solution to the problems of the elderly: the "old system" required mobility, strength, competitiveness, money and keen awareness of the splintering of services-all detrimental to the situation of most ill elderly.

Maddox, George L. and David C. Dellinger. "Assessment of Functional Status in a Program Evaluation and Resource Allocation Model," The Annals of the American Academy, July 1978, 438: 59-70.

This paper describes the inter-rater and intra-disciplinary reliability of the OARS questionnaire. The authors indicated that it takes about 35 minutes to administer the OARS questionnaire and it is a reliable technique for scoring the dimensions of social resources, economic resources, mental health, physical health, and activities of daily living. The paper also briefly describes the U.S. General Accounting Office study in Cleveland, Ohio which has utilized the OARS survey on a defined population of 1,609 persons 65 years of age and over in Cleveland, Ohio.

Minkler, Meredith. "Health Attitudes and Beliefs of the Urban Elderly," Public Health Reports, September-October 1978, 93(5): 426-432.

Selected health beliefs, attitudes and practices of 755 elderly residents in San Francisco were surveyed in 1976. Middle-class, lower-middle-class, and low socioeconomic groups were represented.

A 30-item questionnaire was administered to elicit information on the respondents' general life satisfaction; perceptions of their own physical, mental, and emotional health as compared with that of others in their age group; attitudes toward specific disease prevention or health promotion activities; and beliefs about normal aging processes. The results revealed a tendency for the respondents to evaluate their own personal health and well-being positively as compared with that of others in their age group. However, the numbers of elderly Americans believed to be in nursing homes by the respondents exemplifies the common tendency of the elderly toward negative stereotyping of their own age group. Significant discrepancies were also noted between the respondents' health beliefs (for example, as to the efficacy of influenza vaccines) and their self-reported actions related to health.

Age and sex did not significantly influence responses on the majority of the health-related questions in the survey, but striking differences were observed on some questions when subsamples corresponding to middle, lower-middle and low socioeconomic groups within the community were analyzed separately. anticipated, low-income respondents demonstrated significantly less favorable perceptions of their physical health status than did their counterparts and a far greater tendency to report that they visited a physician "only when feeling ill". Yet, they did not significantly differ from the other respondents in their belief that additional income would not improve their health. The low socioeconomic group also appeared to be misinformed about preventive health behavior to a significantly greater extent than members of the other two subsamples.

Montana Foundation for Medical Care, Summary of Boarding Home Review, September 1979.

This summary describes a 1978-1979 study of Montana retirement homes. Fifteen of the thirty licensed boarding homes in the state were selected, on the basis of potential problems. Since this was not a random selection of homes, there can be little extrapolation to the general population of homes, the residents, or the state population.

One hundred seventy-five clients were reviewed by a nurse coordinator supervised by a physician. No social assessment was included in this review. Five of the 175 residents were eventually found by both the nurse coordinator and physician to need intermediate care. The report estimates that approximately 9% of the 175 residents were inappropriately placed. The report makes several recommendations regarding boarding homes for the elderly and disabled: creation of personal care homes (which currently are not defined and regulated in Montana); screening procedures for placement and alternative living arrangements; third party payment; and common terminology for various types of housing and boarding home arrangements.

Morris, Robert. "The Development of Parallel Services for the Elderly and Disabled - Some Financial Dimensions," The Gerontologist, February 1974, 14: 14-19.

Current financial arrangements for the elderly and disabled favor institutional care over at-home care. Several studies are discussed that reveal that non-hospital based home care programs can be economical for 15-20% of the institutionalized population and for 14% of the non-institutionalized aged. Reimbursement alternatives involving Medicare, private insurance and voluntary organizations are suggested.

Nagi, Saad. "An Epidemiology of Disability Among Adults in the United States," Health and Society, Fall 1976.

In 1972, Saad Nagi completed a survey of disability among adults in the United States. To derive estimates of the nature and amount of disability, Nagi measured the functional ability of adults as it related to both occupational and activities of daily living performance.

To measure functional ability, the author completed almost 6,500 interviews out of a probability sample of 8,090 households across the continental United States. Respondents were asked 15 questions pertaining to physical and emotional performance. To each of these questions a weight was attached which represented the estimated importance of the attendant activity in the total picture of functional ability. The scores were then divided into four categories: 1) no or minimal limitations; 2) some limitations; 3) substantial limitations; and 4) severe limitations.

When Nagi cross tabulated age with the degree of limitations experienced by an individual, he came up with the following results:

Total N = 6487

Age	Substantial Limitations	Severe Limitations	Mobility Assistance Needed	Personal Care Assist Needed
18-44	1.2%	0.8%	0.6%	0.5%
45-54	5.0%	3.6%	2.6%	1.4%
55-64	8.4%	7.4%	5.2%	2.7%
65-74	9.7%	10.1%	8.5%	3.0%
75 and over	22.5%	19.9%	16.7%	9.1%

Of the total sample the author estimated that 3.5% of the persons needed mobility and 1.8% needed personal care assistance.

Nagi clearly draws the connection between limitations in physical performance and emotional performance and the need for assistance with the activities of daily living. The following are his results:

Limitations in Physical Performance	Mobility Assistance	Personal Care Assistance
Substantial Limitations	32.2%	3.2%
Severe Limitations	42.7%	31.7%
Limitations in Emotional Performance		
Substantial Limitations	6.5%	2.8%
Severe Limitations	20.0%	11.7%

Orleans, Miriam. "Mexican-American Elderly in Three Colorado Communities: An Assessment of Needs and Resources; Final Report," National Technical Information Service, Springfield, Virginia, March 24, 1978.

This study was based on 496 interviews of households with an age population of sixty years and older. A questionnaire, in both English and Spanish, was used to obtain data on demographic characteristics, living arrangements, mobility, financial status, interaction with others, capacity for independent living, health status, use of health, social and other services, and attitudes toward nursing homes. Data analysis was primarily descriptive. Those living in larger urban areas were highly similar in health and illness status with multiple musculoskeletal problems most common. High incidences of illness affecting quality of life were reported in all areas, with dental care and heart conditions more prevalent in urban areas and visual problems in the rural areas. Use of health and dental care varied in accordance with availability of resources, with dental care most difficult to obtain. Financial problems were the greatest barrier to seeking all care for which Medicaid and Medicare are the main sources of assistance. There was a preference to remain in the home rather than live in a long-term care facility. Social, welfare, and health care programs do not adequately meet needs. Recommendations and suggested courses of action were proffered to alleviate problems faced by these elderly.

The survey was administered to residents in the Colorado communities of Denver, Greeley, Johnstown, and Milliken. Approximately 9% refused to respond to the interview and 18% of the surveys had to be discarded because of moves or deaths.

Palmore, Erdman. "Total Chance of Institutionalization Among the Aged," The Gerontologist, 1976, 16(6): 504-507.

This study describes the institutionalization percentages of a group of 207 persons in the Piedmont, North Carolina area. These individuals were all community residents aged sixty or older at the beginning of the study in 1955, and died prior to Spring, 1976. In addition, there were 64 survivors who were not included in the analysis. This study presents a well founded statistical analysis on the incidence of institutionalization (chronic disease hospitals, nursing homes, and homes for the aged) of the elderly during their senior years. The only apparent shortcomings of the study are in extrapolating from this particular geographic area to others and the desirability of a larger sample size.

The study showed that during the twenty years, 26% of the population was institutionalized one or more times before death, and the vast majority died in an institution. (Of those institutionalized, all but one stayed for more than six months which is an empirical finding which is counter to some unsupported assertions of other researchers about lengths of stay of the elderly in institutions).

Some of the statistically significant findings are the following: persons living alone have a 33% probability of being institutionalized; persons never married or separated have a much higher probability of being institutionalized than those who have a spouse present or are widowed; persons with no, one, or two children have a much higher probability of being institutionalized than those with three or more children; women are much more likely to be institutionalized than men; and persons with adequate financial resources are much more likely to be institutionalized than those who cannot makes ends meet. The latter, unexpected finding is thought to be related to the fact that persons with financial resources can buy their way into institutions, but later become financially dependent because of the depletion of their savings and other resouces. This study also found that institutionalization is very much a function of age, with 2% of persons from age 65 to 69 being institutionalized as compared to 14% at ages over 85.

This study is scientifically sound and an important contribution to the literature on being able to project utilization of institutions by the elderly on the basis of demographic characteristics and financial resources.

Pfeiffer, Eric, editor. Multidimensional Functional Assessment: The OARS Methodology, A Manual, January 1976, Center for the Study of Aging and Human Development, Duke University, Durham, North Carolina.

This manual describes work begun in 1971 by the Duke University Center for the Study of Aging and Human Development to undertake a series of research studies which would explore alternatives to institutional care for impaired older persons. Part of this work resulted in the development of a reliable and valid practical assessment methodology known as OARS (Older Americans Resources and Services). The manual and instrument development took approximately four years.

This manual includes a justification for a detailed instrument, describes the steps used to validate and test the reliability of the instrument, and describes three studies that have been undertaken with the instrument. The OARS methodology has been very well thought out and designed with emphasis placed upon good design, testing for validity and reliability, uniform training and instructions, and dissemination of study results.

Quinn, Joan L. "Triage: Coordinated Home Care for the Elderly," Nursing Outlook, September 1975, 23(8): 570-573.

Under the aegis of the Council on Human Services, a three-year project to coordinate a system of home care for the elderly was initiated in a seven-town area in Central Connecticut. The objectives of "Triage" are to:

- Provide a single-entry mechanism by which the elderly's needs are evaluated
- Develop the necessary preventive and supportive services
- Integrate efforts to give coordinated care
- Create financial support as needed
- Evaluate and determine the cost-effectiveness of the program.

The more than 100 referrals per month came from 27 different sources, including visiting nurses, senior centers, clergy and physicians, or the client concerned. A geriatric nurse-clinician makes the initial client contact, assesses the client's needs and performs a physical exam; the social worker and the nurse then decide on the services the client should use and facilitate utilization of them. Follow-up is also an important part of the team effort. Case studies were presented to demonstrate program success, but as yet, cost effectiveness has not been tested.

Quinn feels that the most important aspect of "Triage" is its ability to help the elderly client feel his worth in life and to ultimately die with dignity.

Ries, Bernard and Jon B. Christianson. "Nursing Home Costs in Montana: Analysis and Policy Applications," Montana State University (Bozeman, MT), Montana Agricultural Experiment Station, Research Report 117, December 1977.

This study is based upon 1974 data collected from fifty of the seventy-five nursing homes in Montana. This study particularly addresses the issues of whether or not type of ownership and size of nursing home contribute to significant differences in nursing home cost. Because of data confounding programs, the eight reporting nursing homes that are operated by a hospital were excluded from the analysis.

The major study conclusions are:

1. The economies of size and the different cost categories studied imply that larger facilities are more efficient and less costly, up to a point. The optimal nursing home size was calculated to be 122 beds, although the authors describe several problems associated with consolidating institutions to this size and note that most nursing homes in Montana are substantially smaller than this number.

2. There is no significant change in the economies of size for homes located in smaller communities.

3. Facilities run for profit do have lower cost, which may be due to the profit incentive or a different mix of services and patients.

4. The overall effect of location, as defined in the study, is minimal to the determination of cost.

5. The greater the proportion of licensed SNC beds in a facility, the higher the cost per patient day. Costs apparently do increase as required services become more intensive.

This study does not address alternatives to nursing home care.

Schlenker, Robert E., et al. "Home Health Grant Program Evaluation--Executive Summary," Center for Health Services Research, University of Colorado Medical Center, Denver, Colorado, March 1979.

This study analyzes the Federal Home Health Grant Program by analyzing 56 home health agencies which received Federal grant awards in 1976 totaling three million dollars. The two primary evaluation criteria utilized are capacity development and financial self-sufficiency of the agencies.

The number of visits related to the grant was used as the principal indicator of capacity development. During 1977, the year following the award of the grants, the average expansion agency provided 1,200 grant related nursing visits and 1,000 allied visits. (Allied visits are those made by home health aids, therapists, and social workers.) The average developmental agency provided 1,000 nursing visits and somewhat less than 400 allied visits. For the 39 grantees with reliable cost data, visits cost an average of approximately $18. This cost had a wide range among the agencies, with the Visiting Nurse Associations having the lowest average cost per visit of $10.75.

While most of the grantees received more total revenues than total expenditures, the amount of revenues generated from patient care services was consistently less in relation to total expenditures. About half the grantees covered less than half their total expenditures with patient care revenues. These findings suggest that in order to sustain the same level of expenditures after grant funding ends, grantees will have to increase their patient care revenues considerably.

The study identifies important factors to success: financial self-sufficiency was strongly related to reliance on Medicare reimbursement for operating revenues, Visiting Nurse Associations provided significantly more visits per grant dollar than other types of agencies, state agency grantees did less well than other types of agencies in terms of financial self-sufficiency measures, and agencies located in preference areas were not as successful in achieving either program objective.

There is no reference in this article to treatment of the elderly, or comparisons with institutional programs.

Scutchfield, F. Douglas and Donald K. Freeborn. "Estimation of Need, Utilization, and Costs of Personal Care Homes and Home Health Services," HSMHA Health Reports, April 1971, 86(4).

In 1970 Scutchfield and Freeborn conducted a study designed to determine the feasibility of implementing home health services and personal care homes into the health care system of rural Northeastern Kentucky. The authors' approach was to submit a questionnaire with the charts of all of the patients admitted to the 40 bed primary hospital servicing a four county area. The attending physicians were asked to provide the patient's demographic information and to suggest how that patient would have been differently placed had personal care homes and home health services been available. Questionnaires were at least partially completed for all 318 eligible patients; all admittees being eligible except pediatrics under age 14, obstetrical patients, and those who died while in the hospital.

The authors found that 66 (21%) of all eligible patients would have been referred to home health care had it been available. The attending physicians estimated that the home services required would have amounted to an average of two hours weekly for three months. Medicare and Medicaid would have provided the primary reimbursement for this program, had it existed, since only 9.3% of the patients who would have been referred to a home health service would not have been covered by at least one of these programs. Patients over age 60 would have constituted 86% of the total number referred to home health services, those 70 years and older, 70%.

Seidl, Fredrick W., Carol D. Austin, and D. Richard Green, "Is Home Health Care Less Expensive?" Health and Social Work, May 1977, II(2): 6-19.

This work describes a methodology for comparing the costs of the home care program to nursing home care. It points out the usual falacious argument which compares a day of home health care cost to the cost of a nursing home day. The first major point the authors make on this issue is the necessity of identifying "who but for" clients who would be in a nursing home if it were not for the availability of the home health care program. The authors correctly indicated that very often the home health care programs will provide services (and incur costs) for a number of clients who are not "who but fors". This increases the total cost of the home care program and must be included as a basis for comparison with the nursing home care situation.

The authors correctly point out that in conducting such an analysis, the average number of days of service a client would receive in the home care program must be compared with the number of days in a nursing home. They indicate that that utilization data is not readily available at this time.

The authors cite the work of Greenberg, who suggests that the disability level of clients will also determine the cost effectiveness of home care programs. He argues that the more disabled the client, the more likely that the nursing home can provide the intensive and wide range of services required in a cost effective manner, as compared to the less disabled client who may require only one service on a less than daily basis.

In analyzing the costeffectiveness of home care, the authors also correctly point out that no nursing home costs are saved unless the appropriate placement of individuals in home health care programs results in either fewer nursing home beds or a lower occupancy of nursing home beds. If it is important to control costs, the authors point out, there is a preference for non-provider, centralized case management. This avoids the provider's conflict of interest in conducting the case management and the inherent problems associated with decentralized case management which include the potential for employing different standards and different local communities and the potential for clients who do not meet the service definitions to become recipients in the home care service.

This article also stresses there are important start-up costs in developing alternatives to nursing home care. New services need to be created and this takes time and can be frustrating. These start-up costs and the initial low service volume may result in short run inefficiencies and higher unit costs. New Personnel need to be recruited and trained for the provision of home health and homemaker services.

There is a very interesting description of how to analyze costs in terms of public vs. private when comparing alternatives to nursing home care to nursing home care. The authors stress the importance of considering all of the public and private funding sources, not just Medicaid or total cost. There also are potentially significant socioeconomic costs which are most difficult to measure, including an improved lifestyle for the client and the client's family. Most important, however, is to not just address the costs in terms of Medicaid program dollars or total cost. All significant state, federal, and private funding should be included.

Select Committee on Aging, Comm. Pub. No. 95-139, Home Care for the Elderly: The Need for a National Policy, February 22, 1978, Hearing before the Select Committee on Aging, House of Representatives, Ninety-Fifth Congress, Second Session.

The hearing contains expert testimony from a variety of federal and local sources. Of particular interest is the testimony by the GAO, DHEW (HCFA), Triage (a local Connecticut project), and the comments from an informal conference held in December, 1977 by Representative Max Baucus of Montana.

Based upon Social Security Administration actuary estimates, the GAO reports the following costs for expanding the availability of home health care services under Medicare:

- Eliminate limits on the number of visits in Parts A and B — $ 12.5 million
- Eliminate the skilled care requirement for Parts A and B — $ 1.25 billion
- Eliminate prior hospitalization requirement under Part A — $ 12.5 million
- Eliminate homebound requirement under Parts A and B — $ 92.5 million
- Add homemaker services with restrictions — $ 75. million.

Medicaid offsets are not taken into account in making these estimates. Therefore, all of them are high except perhaps the last. On a national basis, eliminating the limits on the number of visits under Part A and B, and eliminating the prior hospitalization requirement under Part A are the least expensive. The GAO also recommended a single entry point for elderly to coordinate alternative care services.

Mr. Derzon gave the primary testimony for the Health Care Financing Administration of DHEW. He explained that a major report from HCFA was due on alternative care to nursing homes by October 25, 1979, and that he was not prepared to make definitive costs and other statements at this hearing. He indicated that it is much harder to administer the standards for small, geographically dispersed home health services than it is to accredit a hospital, and there is concern about the lack of adequate standards under Title XX for which HCFA does not have direct administrative responsibility.

Three specific alternative care programs were discussed, including Triage in Connecticut. Ms. Joan Quinn presented the Triage testimony. Much of the general testimony, as is the case in other hearings, is based upon representative cases and not directed toward the experimental population outcomes. Triage started in 1974. Through December 31, 1977, there have been 4,002 referrals to the Agency. Of these, 1,844 clients have been assessed by seven nurse-clinician social service coordinator teams. The total number of active clients on December 31, 1977 was 1,384. Over 2,000

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clients wait to be seen. The services available under this expanded Medicare program include: short-term acute hospital care, long-term chronic or convalescent care, visiting nurse, home health aide, day care, meals-on-wheels, chore, homemaker, transportation, volunteer visiting, telephone reassurance, and the traditional physician, dental, podiatry, laboratory, radiology, physical therapy, and pharmacy services. Cost comparisons are presented for the first twelve months experience of health care expenditures among the 20% sample of Traige experimental clients (59 clients) who entered Triage between September 1976 and January 1977. Monthly per capita costs range from $314 to $66 depending upon level of risk. Persons between 75 and 84 had the highest annual per capita cost ($2927) while those persons between 65 and 74 years of age had the lowest annual per capita cost ($1407). Persons in the sample 85 years and older had an average per capita health care expenditure of $2277. The monthly cost for skilled nursing facilities in the Triage region ranges from $900 to $1300 for room and board alone, based upon Medicare reimbursement rates. The number of individuals in this sample is small (59) and it is not stated in the report whether or not both the program costs and the nursing home costs include all health care expenditures or only those included in the two individual programs.

Representative Baucus reported on an informal conference held in Montana in December, 1977 on the home health care issue. Several Montana organizations testified, including comments on the certificate of need and planning review process, the fact that many Montana counties doe not have access to a licensed home health agency, and in Lake County two agencies had been certified for a relatively small county.

The hearing testimony also contains three papers by Dr. Philip Brickner and his colleagues in New York City. One cost analysis comparing the St. Vincent's program with the average nursing home costs in New York City indicates that the hospital based home health care program costs less and the differences are greater as the patient goes from an ambulatory state to a bed-bound state. Annual costs for the St. Vincent's program range from $7,035 to $12,079 which compares with an average nursing home cost ranging from $8,266 to $32,162. All costs are in 1975 dollars. The St. Vincent's program costs are broken out into several components, including utilization per year and cost per visit.

Select Committee on Aging, [Committee Print], New Perspectives in Health Care for Older Americans (Recommendations and Policy Directions of the Subcommitte on Health and Long-Term Care), January 1976, Select Committee on Aging, House of Representatives, Ninety-Fourth Congress, Second Session.

Several different studies are reviewed in this report. Six home care programs are identified which have saved money due to reduced hospital days. The days saved per patient range from 12.9 to 49.8 and the net savings per patient range from $330 to $4590. The latter category are patients in traction in Rochester, New York for 1973. In four of these studies, the number of hospital days saved per patient is based upon physician judgment, not experience.

A January 1975 DHEW study cites figures indicating that between 14 and 25% of the approximately one million elderly persons in skilled and intermediate nursing homes may be unnecessarityly maintained in an institutional environment. Alternatives suggested include: outpatient clinics emphasizing geriatrics, multi-purpose senior centers, community care organizations, elderly day health care centers, and geriatric mobile health units. A number of recommendations for expanding Medicaid benefits are included in the report.

Shanas, Ethel. "Health Care and Health Services for the Aged," The Gerontologist, 1965, (5): 240, 276.

National studies indicate that only about 4% of all persons over 65 in the United States live in institutions. Seven percent of all persons over 75 are in institutions, compared to only 2% of those between the ages of 65 and 75. However, it is estimated that between 7 and 8% of all old people in the United States are bedfast and home-bound at home.

Smith, Bert Kruger. The Pursuit of Dignity. Boston: Beacon Press, 1977.

PL 92-603, Section 222, (Social Security Amendments of 1972) authorized the first federal expenditures for experimental programs to provide Day Care Services for individuals eligible to enroll in the supplemental medical insurance program. In June 1974, six contracts were awarded for experimental programs. Day care and homemaker services were offered by the San Francisco Home Health Service and the Lexington-Fayette County Health Department programs. Day care services only were offered by Burke Rehabilitation Center in White Plains, New York and St. Camillus Nursing Home in Syracuse, New York. Two other contracts, for homemaker services only, were given to Inter-City Home Health Association of Los Angeles and Homemaker-Home Health Aid Service of Rhode Island. These six projects were evaluated for their effectiveness by Medicus, Inc. under contract to DHEW.

The author cites a study conducted by TransCentury Corp. of Washington, which showed that in a study of ten day care centers, the average cost at several centers was approximately $21.04 per day. This compared with an average cost of nursing home care of $18.00 per day at that time. However, the researchers cited many minor discrepancies which would tend to bring these two numbers very close together. It is also noted that the average day care resident might only attend ten to twelve days per month, whereas the nursing home resident would average thirty days per month.

The author summarizes the work of Dr. Eric Pfeiffer, who suggests a multi-dimensional plan for dividing the functional levels of persons into the following categories: physical functioning, psychological functioning, social resources, economic resources, and activities of daily living. He also recommends rating each person on each dimension according to these functional levels: outstanding function, average function, mild impairment, moderate impairment, severe impairment, and total impairment.

The author describes several model programs briefly, including: The Minneapolis Age and Opportunity Center, the Levinson Institute, and the Chelsea-Village Program in the lower west side of Manhattan.

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The author describes several model programs briefly, including: The Minneapolis Age and Opportunity Center, the Levinson Institute, and the Chelsea-Village Program in the lower west side of Manhattan.

Somers, Anne R. and Florence M. Moore. "Homemaker Services--Essential Option for the Elderly," Public Health Reports, July-August 1976, 91(4): 354-359.

Although the elderly prefer to remain at home when possible, and the Senate Subcommittee on Long-Term Care found home health care to be appealing from a number of standpoints, Somers and Moore state that the number of agencies providing homemaker services is not growing rapidly enough in relation to need. (At time of writing, there was one homemaker for every 5,000 persons compared to, for example, Sweden with 1:121 or United Kingdom with 1:726.)

As part of the home health care team, the homemaker provides the elderly with assistance in personal and household tasks they can no longer do themserves, as well as providing emotional support; some homemakers even assist in physical or speech therapy under supervision. The authors stress the importance of monitoring the quality of homemaker services. The National Council for Homemaker-Health Aide Services developed a set of standards in 1965 to begin the evaluation process.

Unpublished data to the National Council for 1974-75 indicate a cost of $5.28 per hour of homemaker services, averaged across 74 projects. The authors argue that this figure is misleading, because all services essential to maintaining a person at home were not included. Additional data are needed--uniformly reported and taking into account placement appropriateness, case by case. A study by the National Council pointed out that in-home care can be custom-fitted to individual needs, whereas institutional staffs are on-duty around the clock, regardless of patient census. Of course, benefits of home health care may not seem so positive when it is realized that third parties will not reimburse for home services; and Federal money is slow in coming to beef up the home health programs. These problems are further intensified by the priority given to acute illness by health professionals; the large amount of investment made in institutional facilities; changing consumer attitudes; and fear by third parties that noninstitutional abuses will be impossible to detect. A national policy on long-term comprehensive care for older Americans is needed, and homemaker services form a vital component of the envisioned continuum of care. The authors conclude their article with a series of recommendations for the leaders of the health professions:

1. Agree on a definition of homemaker service.

2. Agree on standards to assure good services and/or mechanisms to monitor program quality.

3. Extend the New York State Hospital Code which requires all hospitals to have a discharge planning program to other states.

4. Agree on a standard recordkeeping and accounting system.

5. Implement the recommendations of the Senate Subcommittee on Long-Term Care.

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6. Encourage coverage by third parties of home health services.

7. For national health insurance, formulate a realistic package of home health benefits to be included.

8. Encourage employment and training of homemakers under CETA and other programs.

Special Committee on Aging, Alternatives to Nursing Home Care: A Proposal with Discussion of Deficiencies in Federally-Assisted Programs for Treatment of Long-Term Disability, October 1971, prepared for use by the Special Committee on Aging, United States Senate by the Levinson Gerontological Policy Institute.

This study was prepared by Dr. Robert Morris of the Levinson Gerontological Policy Institute at Brandeis University in 1971. It describes both cost and utilization estimating procedures, and performs these estimates, although the data in many cases relates only to Massachusetts and is ten years old.

Estimates for volume of need for personal care at home are included in the paper, including the number of elderly most likely to use help in the United States. The various methods indicate that approximately 10% of the elderly population would make use of the home help benefit. The researchers suggest the consideration of a capitation method as one way of introducing alternative care programs for the elderly without requiring any radically new administrative structure at the beginning. The researchers estimate personal care visits at home by minimum skilled staff will cost approximately $7 per visit. Home-bound patients would require two visits per week, and patients with trouble getting around would require one visit per week. Ballpark estimates are made of the costs and savings for such programs for the United States in 1971.

This report suggests that potential providers of personal care include several organizations which now exist including: Visiting Nurse Associations, homemaker services, hospitals, senior citizen organizations, and other existing medical providers. Medical groups or HMOs could provide a parallel system for personal care if they are prepared to recognize the differences between medical and personal care and are ready to maximize use of less costly alternatives. The authors note that most of the views expressed in this report on the organization of alternatives to nursing home care are based upon urban experiences in the United States and Western Europe. There is insufficient data to predict with any confidence that this approach will serve rural areas as well as it will serve urban and suburban ones.

A 1969 Massachusetts' study indicates that only 37% of the elderly currently institutionalized belong in nursing homes, whereas 23% belong in home nursing or intermediate care, 26% require supervised or shared living, and 14% should have independent living arrangements. The researchers estimate that for the state of Massachusetts, only one in forty elderly persons in probable need of personal care services are receiving them.

Stanfield, Rochelle L. "Services for the Elderly: A Catch-22," National Journal, October 28, 1978, 10: 1718-1721.

This study cites a project in the Arkansas Office of Aging which has provided two million dollars to test and start up a case management program which will treat the service needs of the elderly on the individual basis.

Tilquin, C., et al. "Patient Classification Systems by Level and by Type of Their Needs in Long Term Care," (Paper presented at the "ORSA-TIMS Joint National Meeting," May 1-3, 1978, New York City.).

This study proposes a patient classification system for long-term care which operates in several phases. The first phase involves an extensive physical and social assessment to be performed by a physician and social worker. The second phase involves a review by a multi-disciplinary team to determine the patient needs. The third phase involves a determination of a level of care required by the patient. The authors indicate that forms have been developed for phases one and two, although the instruments shown in the report only contain topics, not definitions of terms or quantitative procedures for recording information. Forms for the third phase were under development. No empirical data is reported.

University of North Carolina, Hospital Based Long Term Care Units in North Carolina. Chapel Hill, March 1972.

In 1972, Harvey Archer coordinated a study of the demographic and health care characteristics of the patient population in hospital based long term care units in North Carolina. The purpose was to identify possible barriers which would inhibit the movement of patients to appropriate care facilities. To collect the necessary information, the study was designed such that multi-disciplinary observation teams composed of physicians, nurses, senior medical students and hospital administrators visited 320 long term patients in both control and study group hospitals in late summer 1970. The data was obtained from the patient's medical record and the opinion of the charge nurse on his/her floor was accepted as to the most appropriate placement for that patient.

The study teams found that of the 320 patients in the project, 87 (27%) were inappropriately placed. Of these it was determined that 16 (18%) would have been more appropriately placed in limited home care, which they define as including public health nursing, meals on wheels, and other homemaker services. An additional 5 patients would have been more appropriately placed in organized home health including those services which require more skill. When considered as a whole, seven percent of those interviewed were considered by the charge nurses to have a health status such that they would have been better placed in some level of home health care.

University of Rochester School of Medicine and Dentistry, Patient Care Planning Council (now the Health Council of Monroe County, Inc.), and the Council of Social Agencies of Rochester and Monroe County, Inc., Health Care of Aged Study: Part II, An Analysis of Some of the Costs of Health Care for Older People in Monroe County, New York, 1968.

Industrial engineering time study data was utilized to estimate the cost of care to the elderly population of Monroe County, New York, for various health care services. The periods selected for gathering time data were randomly selected; however, the institutions observed were not randomly selected. Summary of costs per day, or per visit, for persons aged 65 and over at the levels of care studied for the period 1963-1966 are the following:

University Medical Center per day	$ 49.95,
300-350 bed general hospitals per day	$ 43.16,
100 bed general hospitals per day	$ 36.22,
Acute psychiatric unit cost per day	$ 53.15,
Intensive nursing care costs per day	$ 18.64,
Institutional nursing care costs per day	$ 15.21,
Coordinated home care costs per day	$ 7.92,
Home care (public health nursing) costs per visit	$ 6.11, and
Congregate living costs per day	$ 7.97.

This study made a significant contribution to developing a methodology for cost allocations of health care, to elderly, and in general. This was one of the first studies that allocated nurse staffing time in hospitals to specific patient categories.

Weissert, William G. "Adult Day Care Program in the United States: Current Research Projects and a Survey of 10 Centers," Public Health Reports, January-February 1977, 92(1): 49-56.

This report analyzes ten adult day care programs based upon a random sample of thirty patient records for each program. The basic services offered by all ten programs are: lunch, general nursing supervision and services, social work services, and personal hygiene. In addition, six programs provided special diets and seven gave dietary counseling to participants and their families. Three programs made a psychiatrist's services available. Half the programs provided physical and occupational therapy, and two offered speech therapy. Eight of the ten programs had provisions for some transportation for participants.

Although cost information is available for each of the programs, it is not tabulated in this report. The most costly program cost an average of about $62 per day which compares with the average cost for the other nine programs, $21.04. The author claims that with the one high cost exception, the costs fell within a fairly narrow range, but the specific range is not stated. The author states that the average day care cost of these ten programs substantially exceeded the average daily costs of nursing homes which was $15.63 in 1973-1974. However, the author does not report the fact that participants in adult day care programs do not participate every day, nor does he include a comparison of total health care and/or public expenditures.

The author describes two models of adult day care. The first type is narrowly defined in its service objectives and is targeted to a homogeneous group of participants who meet the very specific admission criteria which stresses health status. The second type includes a variety of sub-types. These programs are more oriented to social needs than the first type, but there is little exclusitivity in their goals, participants, or services. Model One programs are predominantly rehabilitation oriented; and Model Two programs are multi-purpose and usually less health oriented than Model One programs.

Weissert, William G., "Costs of Adult Day Care: A Comparison to Nursing Homes," Inquiry, March 1978, XV(1): 10-19.

This paper compares the cost of adult day care to nursing home care based upon a random sample of ten adult day care programs in 1974. Two basic models of adult day care were identified:

> Model I - or day hospital programs which are affiliated with health care institutions and draw patients primarily from them and Model II, or multi-purpose programs which primarily draw patients from the community.

Estimated daily cost for each participant in the ten adult day care programs range from $11.16 to $61.56 with an average of $25.09. Adult day care programs are more expensive than nursing home costs per day because they use more expensively skilled personnel, the transportation costs are significant, and administrative inefficiencies due to larger administrative staffs (which may be due to the smaller size of most adult day care programs as compared to nursing homes). When comparing annual costs of nursing home care to adult day care, the author cites an annual nursing home cost of $7,015.30 per person, which compares with an adult day care program cost of $2,771.60 (for an average of 2.5 day care sessions per week) to $4,434.56 (for four sessions per week). When living costs at home are included for the day care recipient, the costs for adult day care rise to $6,154.20 per year for four sessions a week. These cost estimates assume that comparable patients are being treated in both facilities; however, the author correctly points out that they are receiving different treatment profiles. All nursing home cost estimates are based upon national data and adjusted for inflation to the same time period as the adult day care costs.

Wilkes, Eric. "How to Provide Effective Home Care for the Terminally Ill." Geriatrics, August 1973, 28: 93-96.

Wilkes' article appears to have been written as a guide for the physician or visiting nurse who cares for terminally ill patients in their homes. Most problems for the home patient, as indicated by a survey of terminal cancer patients in 1965, are caused by pain, retention of urine or incontinence, nausea and vomiting, and open wounds. For each of these afflictions, Wilkes lists proper treatments, and also stresses the important role of the family (to be included as much as feasible) and the health professional (must be warm, communicative and understanding). He also discusses management of lesser problems, such as dyspnea, edema and anorexia. In all cases, Wilkes feels that some form of work, however minimal, should be encouraged whenever possible, to preserve the self-respect of the patient. The author devotes the remainder of his article to a discussion of social factors: the fact that younger patients and laborer class patients tend to die at home; and that not all people should die at home (for example, those with mental confusion or intractable pain). He concludes by stating, "It is doubtful whether efforts made to expand and improve the community services will result in any diminishing demand for hospital care at the end, but dying at home should be the norm for the...future. Its circumstances can be improved...by more attention to detail, more energy, more dedication, and a more sensitive interdisciplinary approach. The intimacy and expertise involved in family practice must lead the way in caring for the dying."

Williams, T. Franklin, et al. "Appropriate Placement of the Chronically Ill and Aged: A Successful Approach by Evaluation," Journal of the American Medical Association, December 10, 1973, 226(11): 1332-1335.

Over thirty months (June 1970 through January 1973), 332 patients in Monroe County, New York were evaluated by a physician, nurse, social worker, and medical specialty consultant team for nursing home placement. The evaluations took approximately three hours and included laboratory tests. The total evaluation recommendation process took about one week.

Eighty-two percent of the subjects were over 70 years old. All have had at least one diagnosis of a chronic disabling disorder and 77.7% have had two or more such diagnoses. Only 78% of the patients seen have a personal physician whom they saw on a regular basis. It is significant that 55% of the cases seen were recommended for placement other than nursing home, even though all of the cases would have normally been placed in a nursing home had this special project not existed. Thirty-four percent of all patients seen were recommended for a program of active medical treatment or a trial of intensive rehabilitation therapy. For another 23%, more diagnostic medical studies were sought before a decision was made.

The authors conclude that the yearly savings accrued by diverting approximately two-thirds of the Medicaid patients from nursing homes would be approximately two million dollars, although they do not consider the cost of the screening program, nor do they discuss the eventual placement of diverted individuals into nursing homes at some later time. The authors also cite the need for physicians and public health nurses,with special competence in the types of services rendered by the evaluation units. Most practicing physicians have little experience with the range and types of long-term care settings including assistant services which could facilitate peoples staying at home.

4.0 BIBLIOGRAPHY OF LITERATURE REVIEWED

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3. Report #4: Survey Findings and Status Report

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Appendix J

3. Report #4: Survey Findings and Status Report

REPORT # 4

SURVEY FINDINGS AND STATUS REPORT

Submitted to:

Health Planning and Resources Development Bureau
Montana Department of Health and Environmental Sciences
Helena, Montana 59601

Submitted by:

JRB Associates, Inc.
40 Denver Technological Center West
7935 East Prentice Avenue
Englewood, Colorado 80111
(303) 773-6883

The names of the persons employed or retained by the contractor with managerial or professional responsibility for such work, or for the content of the report, are as follows:

Steven S. Lazarus, Ph.D.
Peter W. Edgerton, B.A.

JRB No. 2-800-02-519-60
Report No. JRB-D-80-01

May 23, 1980

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1.0. INTRODUCTION

1.1. PROJECT SUMMARY

The Department of Health and Environmental Sciences, Department of Institutions, and Department of Social and Rehabilitation Services are working on a Task Force to recommend legislative and budget considerations for the 1982-83 biennium regarding the appropriate investment of state funds towards the necessary support and care of the elderly and mentally handicapped. Some of the services that are considered reasonable alternatives are: homemaker services, adult day care, home health care, meals-on-wheels, personalized nursing care, and sheltered group homes (personal care homes). It is recognized that other innovative mixes of services have been employed to encourage greater independent living by vulnerable people. What is not known is (1) how many people in Montana need assistance to support a relative degree of independence short of institutionalized care, (2) how the people in need distribute among the kinds of care that might be available if appropriate funding were available, and (3) how much these kinds of care cost.

In June, 1979, the Montana Department of Health and Environmental Sciences contracted with JRB Associates, Inc. to conduct a study on the cost of alternatives to nursing home care for the elderly and mentally handicapped. This report is the fourth in a series to be prepared as part of that study. The interpretations of the data presented in this report are preliminary, subject to discussions with the Task Force and additional analyses which may be performed prior to completion of the Final Report. This report was prepared by the Denver JRB office staff.

1.2. REPORT DESCRIPTION

The sections of this report are concerned with various aspects of the survey results and their interpretation. The survey design was presented in Report # 2, Revised on November 5, 1979. Pretest survey results were presented in Report # 3 on December 27, 1979.

The remaining subsections of Section 1 describe the background and results obtained from conducting the survey, from an administrative perspective.

These discussions include: survey response rate, survey item completeness, and survey administration issues. Section 2 presents statewide results from the survey. For the most part, these statewide results are based on a sample size of 1500. Section 3 presents a regional analysis on the appropriate placement in nursing homes and estimates of the number of candidates for alternative care including separate presentations for urban and rural areas. Section 4 includes presentations on the Native American and developmentally disabled sub-populations, as well as technical statistical information.

1.3. JRB SURVEY QUESTIONNAIRE

Appendix A contains the survey questionnaire and instructions utilized for this study. The survey is based on the prior work of Grauer and Birnbom (1975). The instructions are based on instructions supplied by Grauer and Birnbom, the Community Care Organization Project in Wisconsin, and JRB's experience gained during the pretest of 85 surveys.

1.4. SURVEY METHODOLOGY AND ADMINISTRATION

Three population groups aged 65 and over were sampled with the survey instrument. A total sample size of 1500 was proposed as a goal and was achieved. Each sub-population group sample contains 500 respondents. The three population groups are: Medicaid eligibles in nursing homes, Medicaid eligibles not in nursing homes, and non-Medicaid elderly residing in boarding homes. The third group was chosen to represent the non-Medicaid elderly. This group was chosen to represent the non-Medicaid elderly since the population of all HUD-subsidized housing for the elderly is known, which allows for random sampling on a regional basis.

A random cluster sampling approach was utilized for all three population groups. Three hundred respondents were sampled in each of the five State Health Regions. Within each region, 100 respondents were sampled from each of the three groups. The random cluster sampling procedure within each region, was designed to reflect the proportion of elderly living within urban counties within each region. A sequence of counties was selected randomly within each region, reflecting urban and rural sampling requirements. The utilization of counties as clusters preserves the random sampling requirement to present estimates of population statistics at the regional and state level. The cluster

approach saved considerable travel and personnel time expense; or (since the project budget was fixed) allowed for the collection of more surveys than a random sample would have provided. Non-random sampling procedures might have realized a much larger number of surveys completed; however, statistical estimates of population characteristics are invalid under such procedures, unless a census is taken.

This sampling approach has produced a study of unique characteristics. Perhaps the most significant is that pointed out by Dr. Linda Noelker at The Benjamin Rose Institute regarding a rigorous test of the GFRS instrument. One thousand of the respondents to this study form a unique baseline of non-institutionalized, randomly selected community aged who can be followed at one year intervals to validate the predictive ability of the instrument used. Dr. Noelker's comments are presented in Exhibit 1-1. Published "validation" studies have utilized aged who are either institutionalized or are candidates for institutionalization (see Appendix C).

A number of steps were utilized to reasonably ensure the randomness of the sample obtained. Urban counties selected for the study were chosen randomly within Regions 4 and 5 which have multiple urban counties. Up to three survey attempts were made with each respondent, in an attempt to minimize any bias that might result from the non-respondents. Some of the most remote areas of the state were included in the survey. There was no deliberate exclusion of any unique sub-population or geographic area, with the exception of the Boulder, Galen State and Warm Springs State Hospitals. The residents of these three institutions were excluded from the Medicaid nursing home sampling process since they reflect statewide service and therefore their residents could not be described as being representative of regional characteristics.

1.5. SURVEY RESPONSE RATE AND COMPLETENESS

The number of surveys completed for each of the sample groups is presented in Exhibit 1-2. Response rates by sample groups vary from 66 to 97%. JRB held discussions and/or communicated by mail with the Montana Hospital Association, Montana Association for Aging, and the Montana Nursing Home Association in order to achieve maximum cooperation from the nursing home and boarding home administrators. This process was successful in that only two facilities

EXHIBIT 1-1

LETTER FROM DR. LINDA S. NOELKER

The Benjamin Rose Institute

630 Rose Building, Cleveland, Ohio 44115
216 621-7201

Executive Director
Barbara Silverstone, DSW

Associate Directors
Alan C. Beckman, Ph.D.
S. Walter Foulkrod, Ph.D.
Harold E. Fredrick, CPA

December 19, 1979

Steven S. Lazarus, Ph.D.
Director - Denver Office
40 DTC West
7935 East Prentice Avenue
Englewood, Colorado 80111

Dear Dr. Lazarus:

Enclosed are two papers which we have presented on the issue of institutionalization of the aged and the use of Grauer and Birnbom's GFRS as a placement indicator. I have not seen a rigorous test of this instrument reported anywhere in the literature. That is, a study has not been conducted in which a population or random sample of community aged were surveyed with this instrument and then followed up for at least one year in order to assess the instrument's predictive validity. In our study we included only aged clients of the Institute who were recommended for placement compared with a sub-group of clients who received only home aide service.

To discover if any futher testing of the GFRS has been carried out, I suggest you contact the following person:

Mr. David Mangen
1114 Social Science Tower - Sociology
University of Minnesota
Minneapolis, Minnesota 55455
(612) 376-7178

He is responsible for a project which has compiled all instruments used in aging research as well as critiques of these instruments. The GFRS is included among them. I hope this material and information is helpful to you. If you have any additional requests, do not hesitate to call upon me.

Sincerely,

Linda S. Noelker, Ph.D.
Senior Research Associate

LSN:ne
Encl.

EXHIBIT 1-2

SURVEYS COMPLETED BY SAMPLE GROUP

SAMPLE POPULATION	NUMBER ATTEMPTED	NUMBER RESPONDING	PERCENTAGE RESPONDING
Medicaid, Nursing Home	513	500	97.5%
Medicaid, Non-Nursing Home	756	500	66.1%
Non-Medicaid, Non-Nursing Home	560	500	89.3%
TOTAL	1829	1500	82.0%

refused to participate, Park Place Nursing Home in Great Falls and Hearthstone, Inc. in Anaconda. In several other cases, individuals closely followed the JRB surveyors within the institution; however, although this was annoying and somewhat disruptive, it did not substantially interfere with the survey process.

The survey item completeness was very high. Exhibit 1-3 presents survey item completeness for the primary questions. The item numbers refer to the survey items which are fully described in Appendix A. All survey questions which normally would have been answered by all respondents have a response rate of at least 97.5%. Per cent completed statistics are all based on 1500 surveys; however, in many cases the proportion of the sample for whom the response is inapplicable is significant.

1.6. SIGNIFICANT ADMINISTRATIVE ISSUES

Montana Department of Social and Rehabilitation Services was very cooperative in supplying the lists of Medicaid recipients. At times, staff were under great pressure to produce these materials in time for the study to proceed. Many minor problems were encountered; however, these materials were prepared and delivered in a timely manner which allowed the study to proceed, an accomplishment which JRB has not always found achievable by Medicaid programs in other states.

JRB surveyors experienced some difficulty in finding Medicaid recipients with post office box addresses. Lack of frequent airplane services and a shortage of motel space (due to the increase in activity related to the development of the Williston Basin) in Eastern Montana required that thorough advance planning be utilized to efficiently conduct surveying in this Region. Weather throughout the winter was relatively cooperative, with major storms primarily occuring while JRB personnel were in Denver preparing for future surveying trips. In only one instance a flight was cancelled because of bad weather.

In Lewistown, Montana a JRB surveyor was sought by the local police for three days due to a complaint lodged by either a respondent or a non-respondent. When eventually apprehended for questioning, the JRB surveyor was able to adequately explain his presence with the help of the identification card provided by the Department of Health and Environmental Sciences. However, this experience was disruptive to completing surveys in the facility where he was apprehended.

EXHIBIT 1-3

SURVEY ITEM COMPLETION*

SURVEY ITEM	NUMBER OF SURVEY ITEMS COMPLETED	NUMBER INAPPLICABLE	NUMBER NO ANSWER	PERCENT COMPLETED
GFRS SCORE	1500	0	0	100
31. Sex	1500	0	0	100
32. Age	1484	0	16	98.9
33. Type Residence	1500	0	0	100
34. Race	1496	0	4	99.7
35. Income Level	1474	0	26	98.3
36. Children in County	1462	0	38	97.5
37. Financial Support	645	688	167	43.0
38. Own Car	1497	0	3	99.8
39. Private Insurance	1475	0	25	98.3
40. Cover Home Care	428	1052	20	28.5
41. NH Placement Chosen	479	1000	21	31.9
42. Financial Status Stable	52	1447	1	3.5
43. Sell Possessions	52	1447	1	3.5
44. Duration Independence	45	1447	8	3.0

*Includes only survey responses, non-responses excluded
Percent completed based on 1500 surveys

Subsequent to this event, local police departments were notified of JRB personnel surveying activities prior to their commencement.

Respondents to the survey can be hostile. In one instance, an interviewer was chased by a lady with a kitchen knife when she answered his knock at the door. Bystanders can also be unfriendly. An interviewer was accosted by a young adolescent with a knife when he tried to conduct interviews on the "wrong side of town" and on another occasion he was "crowded" by a group of young Native Americans asking for money.

Although severe weather problems did not seriously hinder the conduct of this survey during the winter, problems were encountered. One interviewer suffered a mild "post impact trauma" after falling on ice in a parking lot. This fall resulted in periodic dizziness for about one week. In general, it is preferable to conduct statewide studies in the summer months when the weather is more favorable.

Interviewers need to be capable of confronting and handling the emotional issues faced when conducting surveys of the elderly. In several cases, respondents were experiencing emotional trauma and needed to talk to someone. Interviewers must have the capability to draw a line between being dedicated to completing their work and being compassionate. In some cases, residential units were literally uninhabitable, necessitating great courage merely to enter and sit down to conduct the interview.

A relatively short survey instrument was designed for this study. This decision proved to be a wise one. The survey response rate is high as is the item completeness rate. These statistics are frequently much lower for lengthy survey instruments. In addition, there have been several significant air fare increases between the time that the project was proposed and the survey activity was completed. By being able to administer the survey instrument efficiently and planning travel according to the cluster pattern of the random sample, the impact of the increased air fare costs was minimized. In addition, on several occasions the surveyors worked ten days straight in Montana and took four days off, thus saving several round trip air fares between Denver and Montana.

In summary, the survey process went very well, primarily due to good administrative and efficiency planning. Most of the problems encountered could

not have been overcome by better planning, with the single exception of conducting the survey during a warmer season.

1.7. INTERPRETATION OF SURVEY RESULTS

The remaining sections of this report contain several tables reporting results of the survey. There are two important factors to keep in mind when interpreting these tables. First, all of the percentage estimates are single point estimates. Exhibit 1-4 presents the interval ranges around these percentages as a function of sample size. For example, if the survey shows that in Region 1 2% of the nursing home population has independent functional ability, then the 90% confidence interval around that 2% is approximately plus or minus 5%. In other words, at this confidence level, the percentage could be as high as 7% or as low as 0. At the state level sample of 1500 the same level of confidence is achieved with plus or minus 1%. All of these estimates are approximate and will vary somewhat based upon the specific percentage under consideration. In addition, it must be recalled that the survey instrument is not perfect and therefore relatively small percentages (in the 2 to 5 range) may not be significant.

Several of the statistical tables in Sections 2 and 3 contain separate presentations for urban and rural areas. For the purposes of this study, seven Montana counties were defined as urban. They are listed in Exhbit 1-5 based upon an estimated 3,000 or more elderly residents within the county.

EXHIBIT 1-4

APPROXIMATE CONFIDENCE INTERVALS

Sample Size, n	p, Population Proportion	90% Confidence Interval of p
100	0.1	0.05 to 0.15
300	0.1	0.07 to 0.13
1500	0.1	0.09 to 0.11

EXHIBIT 1-5

MONTANA COUNTIES WITH MORE THAN 3,000 ELDERLY

	Region	County	Major City
1.	Eastern	None	
2.	North Central	Cascade	Great Falls
3.	South Central	Yellowstone	Billings
4.	Southwestern	Gallatin	Bozeman
		Lewis & Clark	Helena
		Silver Bow	Butte
5.	Northwestern	Flathead	Kalispell
		Missoula	Missoula

2.0. STATE LEVEL SURVEY RESULTS

A total of 1500 surveys were completed for state level analysis. Appendix B contains 1975 and 1985 population projections for each Region. 1980 estimates utilized in this study are based on averaging the 1975 and the 1985 projections. Exhibits 2-1 and 2-2 present estimates of the Montana Medicaid over 65 nursing home population and non-nursing home population respectively. The data in these tables are based on January, 1980 eligibility information. For the Medicaid nursing home population, the sample has 18% under the age of 75 compared with 20% for the population. The Medicaid nursing home sample is 75% female compared with 71% female for the population.

The Medicaid at home sample is 47% aged under 75 compared with 50% for the population. Sixty-six per cent of the Medicaid at home population is female compared with 73% surveyed in this category. There is no reason to believe that these small differences in anyway bias the interpretation of the survey results.

Exhibit 2-3 presents statewide results by survey item. These results are based upon 1500 surveys and include both nursing home and non-nursing home respondents. The average GFRS score is 31.64 which means that the average respondent needs alternative care. Seventy per cent of the population surveyed have incomes below $2500 per year. Twenty-nine per cent have private health insurance and 42% per cent of these policies include home care benefits.

Exhibit 2-4 presents the percentage distribution of GFRS scores by age group for the entire state. It is particularly significant to note the results in the column "Less than 20" which related to appropriate placement in a nursing home. As the elderly get older, the proportion requiring nursing home placement grows significantly. It is important to remember when interpreting Exhibits 2-3 through 2-5, these are survey statistics which are not adjusted for the proportions of the population that are Medicaid nursing home, Medicaid at home, and non-Medicaid.

Exhibit 2-5 describes the relationship of GFRS to age for the entire state. The GFRS score of 20 is significant in that it is below this score where institutional placement is indicated. There is a relative stability in

EXHIBIT 2-1

MONTANA MEDICAID OVER 65
NURSING HOME POPULATION BY REGION
AND SEX

Region	TOTAL		AGED 65-74		AGED 75+	
	Number	% Female	Number	% Female	Number	% Female
1	284	63%	61	44%	223	68%
2	632	69%	124	60%	508	71%
3	707	69%	132	52%	575	73%
4	790	75%	185	65%	605	78%
5	647	72%	100	68%	547	73%
State Total:	3060	71%	602	60%	2458	74%

EXHIBIT 2-2

MONTANA MEDICAID OVER 65
NON-NURSING HOME POPULATION BY REGION
AND SEX

Region	TOTAL		AGED 65-74		AGED 75+	
	Number	% Female	Number	% Female	Number	% Female
1	358	64%	168	64%	190	65%
2	859	62%	457	57%	402	68%
3	748	62%	399	62%	349	63%
4	657	72%	326	65%	331	78%
5	772	69%	367	65%	405	72%
State Total:	3394	66%	1717	62%	1677	69%

EXHIBIT 2-3

STATEWIDE RESULTS BY SURVEY ITEM

ITEM	STATISTIC	VALUE
GFRS Score	mean	31.64
% Medicaid Recipients	percentage	66.6%
% Female	percentage	74.8%
% Nursing Home Residents	percentage	33.3%
% White	percentage	97.3%
% Below $2500 Income	percentage	70.1%
% With Children in County	percentage	52.9%
% responding that children would need more than $500/yr to support them in child's home	percentage	51.2%
% Own, Use car	percentage	15.0%
Private Health Insurance	percentage	28.7%
% with private health insurance covering home care	percentage	1.7%
% Financially Independent	percentage	3.2%
% Stable	percentage	18.8%
% Selling Possessions to stay independent	percentage	16.6%
% "Permanent"	percentage	89.6%
Nursing Home Residents		
% Medically Placed	percentage	79.1%

EXHIBIT 2-4

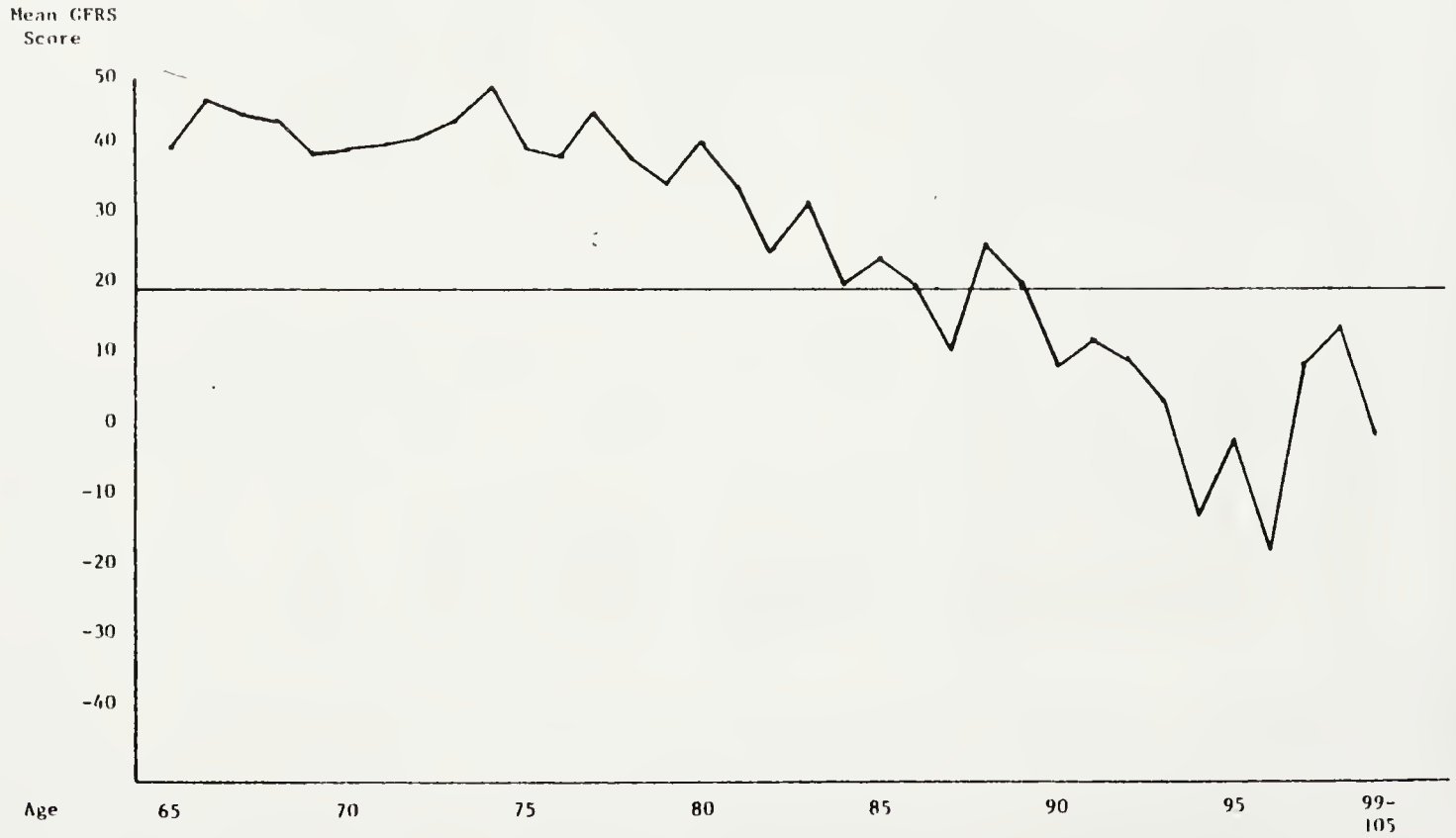
PERCENTAGE OF GFRS SCORES BY AGE GROUPS, STATE OF MONTANA

Sample size, n = 1484

	GFRS		
Age Group	Less than 20	20-39	40 and above
65-74	15.4%	15.7%	68.9%
75-84	26.0%	13.1%	61.0%
85-95	48.3%	17.2%	34.5%
95-105	73.1%	19.2%	7.7%

EXHIBIT 2-5

RELATIONSHIP OF GFRS TO AGE, STATE OF MONTANA



JRB Associates, Inc.

the elderly population's functional ability through approximately age 80. Between age 80 and 85, there is a decline in functional ability, and beyond age 86 a significant portion of the elderly population require institutional care.

Montana GFRS scores for the three population groups, for rural and urban areas, are presented in Exhibit 2-6. The most striking differences between the urban and rural areas are reflected in the Medicaid and nursing home scores, where there appears to be a higher tendency to use nursing homes in rural areas, probably because of reduced opportunity for alternative care in rural communities. Exhibit 2-7 presents average GFRS scores by status and region. A few observations in this Exhibit are noteworthy. First, the relatively low GFRS scores for Medicaid recipients in nursing homes in Regions 2 and 5 indicate lower functional abilities of the nursing home residents in these two regions (perhaps an indicator of more appropriate placement in nursing homes). The relatively high GFRS scores in Region 5 of the two populations at home indicate an appropriate dichotomy between the institutionalized and non-institutionalized elderly in this Region. The relatively low scores for the two populations at home in Region 2 perhaps indicate a larger need for alternative programs since a significant portion of the population at home in this Region would have scores below 40.

Exhibit 2-8 presents a summarized statistical analysis of those variables which relate most significantly to GFRS. The presentation is divided into two sample groups, nursing home with a sample size of 500 and residents at home with a sample size of 1,000. A minus sign preceding the correlation coefficient indicates a negative relationship, which is true for age which is expected. For the nursing home sample, a correlation coefficient of absolute value exceeding 0.115 is significant at the 1% level. For the residing at home sample of 1,000, a correlation coefficient of absolute value exceeding 0.081 is significant at the 1% level. Based on the results from the residing at home sample, further study is warranted to investigate the following variables to possibly develop a predicting formula to prescreen GFRS administration: age, sex, use car, use telephone, private health insurance, and income.

EXHIBIT 2-6

STATE OF MONTANA GFRS SCORES

TABLE a. RURAL (n = 828)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	3%	14%	83%
Medicaid at Home	7%	13%	80%
Medicaid in Nursing Home	78%	19%	3%

TABLE b. URBAN (n = 672)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	5%	14%	81%
Medicaid at Home	2%	17%	81%
Medicaid in Nursing Home	86%	12%	2%

EXHIBIT 2-7

GFRS AVERAGE SCORE BY STATUS AND REGION

Region	STATUS		
	Not Medicaid	Medicaid at Home	Medicaid in Nursing Home
1	57.53	49.74	- 5.13
2	46.74	42.27	-14.70
3	50.98	52.68	- 3.09
4	53.76	49.19	- 6.03
5	56.83	55.64	-12.10
State of Montana	53.17	49.90	- 8.21

EXHIBIT 2-8

GFRS STATISTICAL STATEWIDE CORRELATIONS

Variable	GFRS CORRELATION COEFFICIENT	
	Nursing Home Sample, n = 500	Residing at Home Sample, n = 1000
Age	-0.206	-0.199
Sex (1=male)	0.167	-0.098
Urban County (1=Urban)	-0.121	0.069
Use Car	0.104	0.211
Use Telephone	0.097	0.260
Insurance	0.037	0.187
Income	*	0.161

*Cannot be computed

NOTES: For a sample size of 500, a correlation coefficient of $|0.115|$ or larger is significant at the 1% level.

For a sample size of 1000, a correlation coefficient of $|0.081|$ or larger is significient at the 1% level.

3.0. SURVEY DATA ANALYSIS BY REGION

The series of Exhibits in this Section are organized by Region. The first Exhibit for each Region presents the percentage distribution of GFRS score by status. It is important to note that GFRS scores of less than 20 generally indicate institutionalization, scores between 20 and 39 indicate a support requirement (alternative to insitutionalization), and scores of 40 and above indicate functional independence. The analysis for each Region is conducted separately for rural and urban areas, with the exception of Region 1 which has no urban area.

Exhibits 3-3 through 3-5 will be used for illustrative purposes to explain the information presented for each Region. Exhibit 3-3 depicts the status and GFRS relationship for the rural and urban areas of Region 2. As is expected, relatively small percentages of the non-Medicaid and Medicaid at home populations have scores of less than 20 which would indicate institutionalization. Also, relatively small percentages of residents in nursing homes have scores above 40 which indicate independent functional ability. In this Region and several others, significant proportions of the institutionalized and non-institutionalized populations have scores ranging from 20 to 39 which predict the utilization of an alternative to nursing home care. The GFRS scores are predictive in nature, and therefore some discrepancies of placement versus GFRS score are expected. It is also important to note that a person residing in a nursing home may have been appropriately placed in the nursing home at time of admission and at the time of survey may have been able to utilize an alternative or return to independent living, but these alternatives may not be available. In interpreting the first Exhibit for each Region, attention should be focused on the percentage of each category with scores ranging from 20 to 39, the range in which alternatives to nursing home care apply.

The second set of presentations for each Region consists of one or two estimates of channeling alternative candidates. The channeling alternative to nursing home care is presented for discussion purposes here, since day care programs are very expensive and require large service loads to be potentially

efficient. It is unlikely that these large service loads will materialize in Montana in most communities.

Exhibit 3-4 presents the estimates of alternative care candidates for the rural area of Region 2. Both a high estimate and low estimate are presented. The high estimate calculation for Medicaid recipients in nursing homes who would be eligible for the alternative is performed by multiplying the number of Medicaid recipients in nursing homes in the rural part of Region 2 by the percentage of surveyed Medicaid recipients in nursing homes in the rural part of Region 2 who scored 20 and above on the GFRS (this information is obtained from Exhibit 3-3, table a). The result is 49 nursing home residents who could be displaced from nursing homes if suitable alternatives and the administrative mechanisms are available. The low estimate for Medicaid recipients in nursing homes is 0. This estimate is utilized based on JRB's discussion with ACCESS personnel in Rochester, New York who indicated that almost no alternative to long term care program clients come to the program from nursing homes. However, the program is very successful in providing an alternative to some who are seeking nursing home placement. The second calculation of estimating channeling candidates is performed for the Medicaid at home recipients. The number of Medicaid at home residents in the rural part of Region 2 (485) is multiplied by the percentage of surveyed respondents in this category in the rural counties of Region 2 who have GFRS scores of less than 40. The high estimate yields 32% in this category for a total number of 155. The low estimate takes the same population base of 485 and multiplies it by one-half of the percentage of the sample in this status category who have GFRS scores ranging from 20 to 39. This yields 63 candidates. This more conservative approach is taken by addressing only those who have scores which indicate the use of the alternative and assumes that only half of them would participate in an alternative program. The other half might go into nursing homes or might continue to live in the present arrangement with or without support from family and friends.

The non-Medicaid population for the rural area of Region 2 is calculated by averaging the 65 and over population estimates for the rural counties in Region 2 (see Appendix B) and then subtracting the Medicaid recipients at home and in nursing homes from the same geographic area. This results in 6022 as the population base for this category. No adjustment was made for non-Medicaid

recipients in nursing homes, but it is believed that this is a relatively small proportion of all non-Medicaid recipients living in the geographic area. The high estimate for this Region is based on multiplying this population estimate by the percentage of the respondents in this category who have GFRS scores less than 40. The low estimate is calculated by multiplying this population by one-half the percentage of the respondents in this category who have GFRS scores ranging from 20 to 39. The resulting high and low estimates for this geographic area are 1890 and 786 respectively.

The high and low estimates of the number of candidates for alternatives to nursing home care is presented in this Section for nine geographic regions. Each region has at least 364 (low estimate) candidates for alternative programs. Similar calculations can be performed for subsets of the geographical entities identified in this Section. Each geographic area analyzed in this Section has a sample size of at least 117. This study was designed to be able to make these types of projections at the state and regional level. Projections at the county or sub-regional level may or may not be appropriate, depending upon the characteristics of the population and the geographic base of the sample utilized.

EXHIBIT 3-1

REGION 1 - STATUS AND GFRS SCORE

Table a. RURAL (n = 300)

STATUS	GFRS		
	Less than 20	20-39	40 and above
Not Medicaid	2%	9%	89%
Medicaid at Home	7%	8%	85%
Medicaid in Nursing Home	80%	16%	4%

EXHIBIT 3-2

REGION 1 - ESTIMATE OF RURAL AREA CHANNELING CANDIDATES

	High Estimate	Low Estimate
Medicaid in Nursing Home % GFRS 20+	284 x 20 = 57	0
Medicaid at Home % GFRS Less than 40	353 x 15 = 53	353 x ½% GFRS 20-39, 4 = 14
Non-Medicaid % GFRS Less than 40	10508 x 11 = 1156	10508 x ½% GFRS 20-39, 4.5 = 473
Total Estimate:	1266	487

EXHIBIT 3-3

REGION 2 - STATUS AND GFRS SCORE

TABLE a. RURAL (n = 141)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	4%	24%	72%
Medicaid at Home	6%	26%	68%
Medicaid in Nursing Home	83%	15%	2%

TABLE b. URBAN (n = 159)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	8%	21%	72%
Medicaid at Home	4%	36%	60%
Medicaid in Nursing Home	89%	11%	0%

EXHIBIT 3-4

REGION 2 - ESTIMATE OF RURAL AREA CHANNELING CANDIDATES

	High Estimate	Low Estimate
Medicaid in Nursing Home % GFRS 20+	289 x 17% = 49	0
Medicaid at Home % GFRS Less than 40	485 x 32% = 155	485 x ½% GFRS 20-39, 13 = 63
Non-Medicaid % GFRS Less than 40	6022 x 28% = 1686	6022 x ½% GFRS 20-39, 12 = 723
Total Estimate:	1890	786

EXHIBIT 3-5

REGION 2 - ESTIMATE OF URBAN AREA CHANNELING CANDIDATES

	High Estimate	Low Estimate
Medicaid in Nursing Home % GFRS 20+	343 x 11% = 38	0
Medicaid at Home % GFRS Less than 40	374 x 40% = 150	374 x ½% GFRS 20-39, 18% = 67
Non-Medicaid % GFRS Less than 40	6758 x 29% = 1960	6758 x ½% GFRS 20-39, 10.5% = 710
Total Estimate:	2148	777

EXHIBIT 3-6

REGION 3 - STATUS AND GFRS SCORE

TABLE a. RURAL (n = 138)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	6%	20%	74%
Medicaid at Home	11%	11%	78%
Medicaid in Nursing Home	63%	35%	2%

TABLE b. URBAN (n = 162)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	2%	11%	87%
Medicaid at Home	2%	7%	91%
Medicaid in Nursing Home	81%	17%	2%

EXHIBIT 3-7

REGION 3 - ESTIMATE OF RURAL AREA CHANNELING CANDIDATES

	High Estimate	Low Estimate
Medicaid in Nursing Home % GFRS 20+	344 x 37 = 127	0
Medicaid at Home % GFRS Less than 40	347 x 22 = 76	347 x ½% GFRS 20-39, 5.5 = 19
Non-Medicaid % GFRS Less than 40	6443 x 26 = 1675	6443 x ½% GFRS 20-39, 10 = 644
Total Estimate:	1878	663

EXHIBIT 3-8

REGION 3 - ESTIMATE OF URBAN AREA CHANNELING CANDIDATES

	High Estimate	Low Estimate
Medicaid in Nursing Home % GFRS 20+	363 x 19 = 69	0
Medicaid at Home % GFRS Less than 40	401 x 9 = 36	401 x ½% GFRS 20-39, 3.5 = 14
Non-Medicaid % GFRS Less than 40	8547 x 13 = 1111	8547 x ½% GFRS 20-39, 5.5 = 470
Total Estimate:	1216	484

EXHIBIT 3-9

REGION 4 - STATUS AND GFRS SCORE

TABLE a. RURAL (n = 117)

STATUS	GFRS Less Than 20	20-39	40 and above
Not Medicaid	0%	10%	90%
Medicaid at Home	3%	20%	77%
Medicaid in Nursing Home	77%	20%	3%

TABLE b. URBAN (n = 183)

STATUS	GFRS Less Than 20	20-39	40 and above
Not Medicaid	8%	18%	74%
Medicaid at Home	2%	15%	84%
Medicaid in Nursing Home	90%	8%	2%

EXHIBIT 3-10

REGION 4 - ESTIMATE OF RURAL AREA CHANNELING CANDIDATES

	High Estimate		Low Estimate	
Medicaid in Nursing Homes % GFRS 20+	163 x 23 =	37		0
Medicaid at Home % GFRS Less than 40	130 x 23 =	30	130 x ½% GFRS 20-39, 10 =	13
Non-Medicaid % GFRS Less than 40	7682 x 10 =	768	7682 x ½% GFRS 20-39, 5 =	384
Total Estimate:		835		397

EXHIBIT 3-11

REGION 4 - ESTIMATE OF URBAN AREA CHANNELING CANDIDATES

	High Estimate		Low Estimate	
Medicaid in Nursing Home % GFRS 20+	129 x 18 =	23		0
Medicaid at Home % GFRS Less than 40	103 x 11 =	11	103 x ½% GFRS 20-39, 4.5 =	5
Non-Medicaid % GFRS Less than 40	11,281 x 7 =	790	11,281 x ¼% GFRS 20-39, 3.5 =	395
Total Estimate:		824		400

EXHIBIT 3-12

REGION 5 - STATUS AND GFRS SCORE

TABLE a. RURAL (n = 132)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	4%	14%	82%
Medicaid at Home	5%	9%	86%
Medicaid in Nursing Home	86%	14%	0%

TABLE b. URBAN (n = 168)

STATUS	GFRS		
	Less Than 20	20-39	40 and above
Not Medicaid	0%	7%	93%
Medicaid at Home	2%	9%	89%
Medicaid in Nursing Home	82%	14%	4%

EXHIBIT 3-13

REGION 5 - ESTIMATE OF RURAL AREA CHANNELING CANDIDATES

	High Estimate	Low Estimate	
Medicaid in Nursing Home % GFRS 20+	253 x 14 = 35		0
Medicaid at Home % GFRS Less than 40	343 x 14 = 48	343 x ½% GFRS 20-39, 4.5 =	15
Non-Medicaid % GFRS Less than 40	7342 x 28 = 1322	7342 ½% GFRS 20-39, 7 =	514
Total Estimate:	1405		529

EXHIBIT 3-14

REGION 5 - ESTIMATE OF URBAN AREA CHANNELING CANDIDATES

	High Estimate			Low Estimate		
Medicaid in Nursing Homes % GFRS 20+	394 x 18	=	71			0
Medicaid at Home % GFRS Less than 40	429 x 11	=	47	429 x ½% GFRS 20-39, 4.5 =		19
Non-Medicaid % GFRS Less than 40	9854 x 7	=	690	9854 x ½% GFRS 20-39, 3.5 =		345
Total Estimate:			808			364

4.0. SPECIAL ANALYSES

4.1. SURVEY ITEMS STATISTICS.

Exhibit 4-1 presents the mean and standard deviation for several variables collected with the survey instrument. Of particular note is the GFRS score variable, which has a mean of 31.56 and a standard deviation of 35.0. It is significant that the mean falls within the range of the middle scale of importance (20-39) and that the standard deviation is large. A useful predictive instrument of this type should have a relatively wide dispersion of responses from a sampled population and the distribution of scores should be somewhat centered around the middle of the range of interest. The GFRS appears to perform well on both of these parameters. The statistics for survey items 33-44 are best interpreted by referring to the survey questionnaire in Appendix A.

4.2. RESULTS FOR NATIVE AMERICANS

Thirty Native Americans were surveyed as part of this study. This number is too small to be considered representative of the Native American elderly in Montana. GFRS score distribution by age group for this sample of 30 is presented in Exhibit 4-2.

4.3. RESULTS FOR DEVELOPMENTALLY DISABLED

Thirty developmentally disabled were surveyed as part of this study. This number is too small to be considered representative of the developmentally disabled in Montana. GFRS score distribution by age group for this sample of 30 is presented in Exhibit 4-3. Twenty-three of the 30 developmentally disabled in the sample are in the age group 65-74, a finding which differs significantly from the general elderly population.

EXHIBIT 4-1

SURVEY ITEM STATISTICS

SURVEY ITEM	NUMBER OF VALID OBSERVATIONS	MEAN	STANDARD DEVIATION
GFRS SCORE	1500	31.56	35.00
P.O. Box Number (1=yes)	1500	0.03	0.16
Phone Number (1=yes)	1500	0.58	0.49
Urban County (1=yes)	1500	0.45	0.50
31. Sex (1=male)	1500	0.25	0.43
32. Age	1484	79.41	7.98
33. Type of Residence	1500	2.87	1.05
34. Race	1496	1.04	0.22
35. Income	1474	1.34	0.56
36. Children in County	1462	0.53	0.50
37. Financial Support for Housing	812	1.08	0.60
38. Own and Use Car	1497	0.15	0.36
39. Private Health Insurance	1475	0.29	0.45
40. Insurance for Home Care	447	0.42	1.86
41. Reason for Nursing Home	501	2.12	1.53
42. Financial Status Stability	53	0.34	1.27
43. Sold Possessions	53	0.32	1.27
44. Duration of Independence	53	3.83	2.23

NOTE: Refer to Survey in Appendix A for Survey item question and response details.

EXHIBIT 4-2

GFRS SCORES FOR NATIVE AMERICANS BY AGE, STATE OF MONTANA

Sample size, n = 30

Age Group	n	Less than 20	20-39	40 and above
65-74	13	7.7%	7.7%	84.6%
75-84	15	20.0%	20.0%	60.0%
85-94	2	0	50.0%	50.0%
TOTAL	30	13.3%	16.7%	70.0%

EXHIBIT 4-3

GFRS SCORES FOR DEVELOPMENTALLY DISABLED BY AGE, STATE OF MONTANA

Sample size, n = 30

Age Group	n	Less than 20	20-39	40 and above
65-74	23	52.2%	21.7%	26.1%
75.84	5	60.0%	20.0%	20.0%
85.94	2	100.0%	0	0
TOTAL	30	56.7%	20.0%	23.3%

APPENDIX A

JRB SURVEY AND INSTRUCTIONS

QUESTIONNAIRE #: __ - __ __ - __ __ __

SURVEYOR: _____

DATE OF INTERVIEW _____

ATTEMPTED INTERVIEWS:	Date Completed	Not Completed
1st _____	☐	☐
2nd _____	☐	☐
3rd _____	☐	☐

NURSING HOME: ☐

MEDICAID I.D. # _____

Name: _____

Address: _____

_____

_____zip_____

Telephone #: 406 - _____

Geriatric Functional Rating Scale: © 1975 GRAUER and BIRNBOM

JRB ASSOCIATES, INC. granted permission to use Geriatric Functional Rating Scale, August 17, 1979, by H. Grauer, M.D., for use in this questionnaire (page 2).

31. Sex: _____ 32. Age _____ 33. Type of Residence _____

34. Race: _____
1. White
2. Native American
3. Other

1. Private Home
2. Apartment
3. Boarding Type Home
4. Institution

35. Income Level: _____

1. Below $2500
2. $2500-$7500
3. Above $7500

36. Does respondent have children, with whom he gets along, living in the same county? _____ (yes = 1, no = 0)

If 36 is "yes":

37. How much annual financial support does respondent think children would need to successfully house respondent? _____

1. $0 - $300
2. $300 - $500
3. $500 +

38. Does person currently: own a car, have a valid driver's license, and use the car for transportation? _____ (yes = 1, no = 0)

39. Does respondent have private health insurance? _____ (yes = 1, no = 0)

If 39 is "yes":

40. Does policy cover assistant/home care? _____ (yes = 1, no = 0)

* * (ASK ONLY NURSING HOME RESIDENTS) * *

41. Why was nursing home placement chosen? (ONE "BEST" ANSWER) _____

1. Social: (e.g., family urging)
2. Medical: (e.g., appropriate level or not)
3. Financial: (couldn't afford living and care elsewhere).

* * * (ASK THIS IN CONJUNCTION WITH NUMBERS 28-30, * * * GRF, ONLY IF RESPONDENT INDICATES FINANCIAL INDEPENDENCE)

42. Is financial status stable or changing? _____ (changing = 1, stable = 0)

43. Have you had to, or will you have to, sell possessions to maintain independence? _____ (yes = 1, no = 0)

44. Can respondent estimate duration of independence: _____

1. 0 - 1 year
2. 1 - 5 years
3. Permanent

-continued-

Functional Rating Scale

© 1975 GRAUER and BIRNBOM

I Circle the appropriate score value for each area

PHYSICAL CONDITION							
1. Eyesight	Watches TV Reads Needlework	0	Distinguishes faces	-3	Sees light only	-10
2. Hearing	Normal voice	0	Loud voice	-3	Deaf	-5
3. Mobility	Fully mobile Dresses Carries Parcels Rides bus	0	Uses cane or should use one Dependent on railings	-3	Requires cane & other support Wheelchair	-15
4. Pulmo-Cardio Vascular Function	No restrictions	0	1 flight of stairs 1 city block	-3	Partly or totally bed-ridden	-20
5. Diet	No restrictions	0			Yes	-3
MENTAL CONDITION						
6. Disorientation	None	0	Time	-3	Person & Place	-15
7. Delusions	None	0	Mild-severe Suspiciousness	-3	Overt	-10
8. Memory loss	None	0	Benign	-3	Malignant	-20
9. Energy & Drive	Normal	0			Hypoactive or Hyperactive	-5
10. Jucgment	Intact	0			Impaired	-5
11. Hallucinations	None	0			Auditory-visual	-10

II Circle the score value only when the answer is YES in each area

FUNCTIONAL ABILITIES	
12. Reads and writes letters	+2
13. Able to use telephone	+5
14. Able to bank and shop	+5
15. Able to prepare simple meals and bake	+7
16. Washes, dresses and toilets self without assistance	+5
17. Uses public transportation	+7
18. Able or would be able to take own medication and follow diet	+10
SUPPORT FROM THE COMMUNITY	
19. Ethnic compatibility in neighborhood or residential area	+2
20. If living alone, can get support and help from a relative, friend, neighbor, or janitor	+10
21. Able to shop at reliable grocer's (willing to deliver when necessary)	+5
22. Availability and accessibility of supportive and recreational facilities -	
- Clubs (i.e. senior citizen center, etc.)	+2
- Church, synagogue	+1
- Library	+1
- Park, shopping center, restaurant, movies	+1
23. Geographic availability and accessibility of -	
- Public Health Nurses	+2
- Meals-On-Wheels service	+2
- Homemaker Services	+2
- Friendly Visitors	+2
- Hospital with emergency and clinic facilities	+2
- Public transportation	+2
LIVING QUARTERS	
24. Elevator service or living on ground floor or basement	+3
RELATIVES AND FRIENDS	
25. Not married but lives with compatible and helpful relative or friend	+5
26. Lives with incompatible relative, friend or spouse	0
27. Lives with sole and compatible spouse	+10
FINANCIAL SITUATION	
28. Totally independent	+5
29. Dependent on relatives, relative	+3
30. Dependent mainly on Social Security S.S.I. or other community resources	0

Please check to make sure that this form has been reviewed and completed. You may make additional comments on the reverse side.

INSTRUCTIONS FOR COMPLETING THE MONTANA ELDERLY NEEDS ASSESSMENT SURVEY, INCLUDING THE GERIATRIC FUNCTIONAL RATING SCALE

Prepared by

JRB ASSOCIATES, INC.
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(303) 773-6883

January 24, 1980

The purpose of this needs assessment survey is to facilitate a brief but wholistic evaluation of a person's ability to cope on an everyday basis within the surrounding community. It enables the interviewer to balance the respondents' physical and mental status with the respondents' functional abilities and the resources present (or not present) within the surrounding community that could compensate for any disabilities.

Administrative Procedure

1. The face sheet of the questionnaire is completed during the first interview attempt to enable the interviewer to find the respondent again, and to avoid duplication. It can also be used as an initial check on the respondent's mental status.

2. Items 31-41 on page one are completed first. Items 42-44 are completed in conjunction with items 28-30 on the Geriatric Functional Rating Scale, if applicable. This process gives the interviewer clues concerning the mental status of the respondent.

3. The Geriatric Functional Rating Scale is completed next, on the basis of the respondent's answers to questions and the interviewer's observations. The respondent receives one score each for items 1-11; items 12-30 are scored only as applicable in each specific instance. For Items 1-11, varying degrees of disability are reflected by negative scores.

Rating Scale Procedures

1. Complete all information on the top half of the page by completing the blank spaces with the appropriate response.

2. Beginning under CLIENT PHYSICAL CONDITION, for items 1 to 11, circle one score for each.

3. On all remaining items, 12 to 30, circle only those scores which are applicable.

Specific Instructions, Definitions and Criteria

Items 1-5 (Physical Condition)

Item 3 - Mobility

Disability (negative score) on this item reflects immobility due to muscular or skeletal conditions rather than cardiac - or pulmonary - specific conditions (See Item 4). Impairment is usually due to osteo-arthritis or muscular weakness or spasm secondary to a stroke.

Item 4 - Pulmo-Cardiovascular Function

A negative score on this item reflects immobility due specifically to cardiac or pulmonary condition. If cardiac and/or pulmonary function prevents a person from climbing more than one flight of stairs or from walking more than one city block - Score -3.

While there may be some overlap between these areas, only one extreme negative score is given. Thus, if a respondent is at least partly bedridden (including confinement to a wheelchair when not in bed per se) it must be discerned if this is due primarily to Item 3 or Item 4: if Item 3, a -15 is scored; if Item 4, a -20 is scored--not both.

Items 6-11 (Mental Condition)

These factors are assessable through general conversation; e.g., asking the person how old he/she is, how long he/she has lived where he/she is, where he/she lived prior to that, how he/she likes the neighborhood, weather, and so on.

Item 6 - Disorientation

Score -3 if a person is disoriented to one or more of the following: time of day; day, week, month or year.

Score -15 if the person seems unaware of where he/she is or who he/she is.

Item 7 - Delusions

Try to ascertain:

(a) Whether he/she feels (unrealistically) that some people or institutions are against him/her;

(b) Whether neighbors are (unrealistically) particularly nasty and/or if he/she thinks they are taking things from him/her;

(c) Whether he/she has unwarranted influence over others or is influenced in an unrealistic way by others.

If the answer to one or more of these questions is "yes", circle -10.

If there is an indication of severe suspiciousness, but the person will not admit overt delusions, circle -3. If you cannot detect any delusions, circle 0.

Item 8 - Memory Loss

From your experience with this individual, consider whether he or she knows the following:

(a) Year and place of birth

(b) Year of marriage

(c) Year of arrival to this community (if applicable)

(d) Name of school attended

(e) Previous address

If you feel a person cannot answer 3 of these questions, but would remember date of birth and age, circle -3.

If you feel a person cannot answer any of the questions under Item 8--would he/she know the name of his/her doctor, social worker or volunteer in a club, ages and names of his/her children, and present addresses. If he/she would be unable to answer these questions, or answers very poorly, circle -20.

If he/she would be able to do well on all questions under Item 8, circle 0.

Item 9 - Energy and Drive

If a person is generally sad, apathetic and retarded in his/her actions, he/she is hypoactive and probably depressed. If he/she is restless, agitated and overtalkative, he/she is possibly manic. In both cases, circle -5.

Item 10 - Judgment

Measures "common sense" (the ability to make the right decisions, to dress appropriately, seek help when needed, to budget properly, etc.). If judgment seems intact, circle 0; if markedly impaired, circle -5.

Item 11 - Hallucinations

Most common are auditory. The person will hear a voice or voices when nobody is talking to him/her. Senile persons living alone may "hear" neighbors complaining about them accusing or vilifying them; a widow may "hear" her deceased husband talk to her. Visual hallucinations are very rare. Circle -10 if hallucinations are present.

Items 12-18 (Functional Abilities)

Nursing home respondents are scored on these items solely on physical and mental capabilities, while those not in nursing homes are scored on capability as well as existence of facilities. That is, if the nursing home respondent were living outside a nursing home, and had access to facilities, would these activities be within the person's capabilities? This interpretation is necessary because nursing homes are restrictive environments with policies that often negate functional abilities. As the desire is to be able to compare functional abilities among the sample groups, the restrictive environments must be held as equal as possible - with nursing home residents being considered as dwelling in the immediate surrounding community. The overriding criteria is that the person be capable of carrying out the activity without more than usual assistance needed by an adult.

Item 12 - Reads and Writes Well

Refers to the ability to correspond socially with friends and relatives, and also the ability to communicate with the written word as necessary. Thus, the person must be able to do so in English to receive credit (for this study). There is no difference in scoring for nursing home respondents or those not in nursing homes on this item.

Item 13 - Able to Use Telephone

Respondents not in nursing homes are given credit for this only if they have a telephone available and are physically or mentally capable of initiating phone calls. The rationale is that a telephone is often the only way of getting help in an emergency and is also a means of limited social contact and independence.

Item 14 - Able to Bank and Shop

This question is referring to physical ability to do banking and shopping. If the respondent is unable to do either task without the help of someone else, the respondent will not receive credit for this question.

Item 15 - Able to Prepare Simple Meals and Bake

This question refers to physical and mental factors along with the availability of cooking equipment. The meal must be something more than a T.V. dinner and has to be cooked. Remember that this question and all other questions on this instrument refer to "right now" ability.

Item 17 - Uses Public Transportation

This question refers to actual use of public transportation, not ability to use it.

Items 19-23 (Support from the Community)

Item 19 - Ethnic Compatibility

Respondents receive credit for this if they reside in a neighborhood where they are able to communicate and relate with their neighbors; i.e., there is no language barrier nor gross cultural difference.

Item 20 - Living Alone

If living alone, can get support and help from a relative, friend, neighbor or janitor, when needed.

If the support comes from a friend or relative, that person must be living in the same town. We are interested in availability factor here. If the support is from a janitor, he/she must live on the premises seven days a week. The person(s) should be able to be aware of change in the respondent's condition "daily", if needed. If the respondent fell, and could not reach the phone, would someone check on him/her?

Item 21 - Shopping

Able to shop at reliable grocer (willing to deliver when necessary). Here we are looking for a reliable grocer who is willing to deliver groceries for the client. We are not looking for the ability of the client to get out and shop.

Items 22-23 - Availability of Resources and Facilities

Credit is received for these if such facilities and services are available within the community for use by the respondent - whether the respondent utilizes them or not. Information sources include:

Nursing Home and Boarding Home
Administrators and Nurses

List from Montana Office on Aging.

Item 24 (Living Quarters)

Item 24 - Home Access

Respondents receive credit for this only if they can enter and exit their home without having to use stairs.

Items 25-27 (Relatives and Friends)

Items 25-27

Self explanatory, except that number 26 is also scored if the respondent is living with someone who is not able; i.e., if the person with whom the respondent lives could not render assistance in an emergency.

Items 31-44 (Supplemental Questions to the GFRS)

Item 33 - Residence

1. Coded for a single family dwelling, whether the respondent owns, rents, or shares it.

2. The unit must include cooking facilities, a bathroom and sleeping area. If such a unit is part of a facility which offers congregate meals, a centrally located staff person on duty, and possibly maid service and telephone "check up", it is coded as a Boarding Type Home (see number 3).

3. Some such facilities offer only rooms (with no cooking facilities); others offer full apartments with cooking facilities. Ultimate criteria are that congregate meals be available, and there regularly is a centrally located staff person on duty to render needed assistance. The differentiation between rooms and apartments will be the respondent's scored ability to "prepare simple meals and bake" (Item 15).

4. This is scored for licensed nursing home facilities.

Item 34 - Race

Response based on physical appearance, name, and Medicaid data. Respondent is asked directly if there remains doubt.

Item 35 - Income

This represents household income in instances where husband and wife are residing together. It is noted on the questionnaire that the coded income level is for two people. For statistical analysis, each person is given credit for one half the total scored amount.

Item 38 - Car Ownership/Usage

This item may reflect one reason for a respondent not using public transportation (Item 17) when this latter is available.

Item 40 - Coverage of Assistant/Home Care

This reflects the respondent's answers to the best of their knowledge. It does not necessarily reflect the actual stated coverage of the specific policy.

Item 41 - Placement

This question is concerned not with the current "reason" for nursing home residency, but the perceived reason - by the respondent - at the actual time of placement.

Item 42 - Financial Status (only if independence is indicated)

Financial independence

Means that the person's income is earned income, not money from friends, relatives, pensions or public sources. If the person is supported only by a pension and Social Security, he/she is not independent. If the person receives a pension, but also receives income from land, farming, substantial interest, or part-time employment, etc., and receives less than half support from public monies (including Social Security), etc., he/she is independent, if the public monies are not necessary for basic subsistence.

Stable

Means that the individual has a steady source of earned income (e.g., land, farm, etc.) that is for all practical purposes not likely to fluctuate drastically, nor liable to be used up. Living off savings which are concurrently dwindling does not classify as stable.

Face Sheet

Questionnaire #

__ Region Code 1-5,

__ __, County Code,

__ __ __, Sequence Number

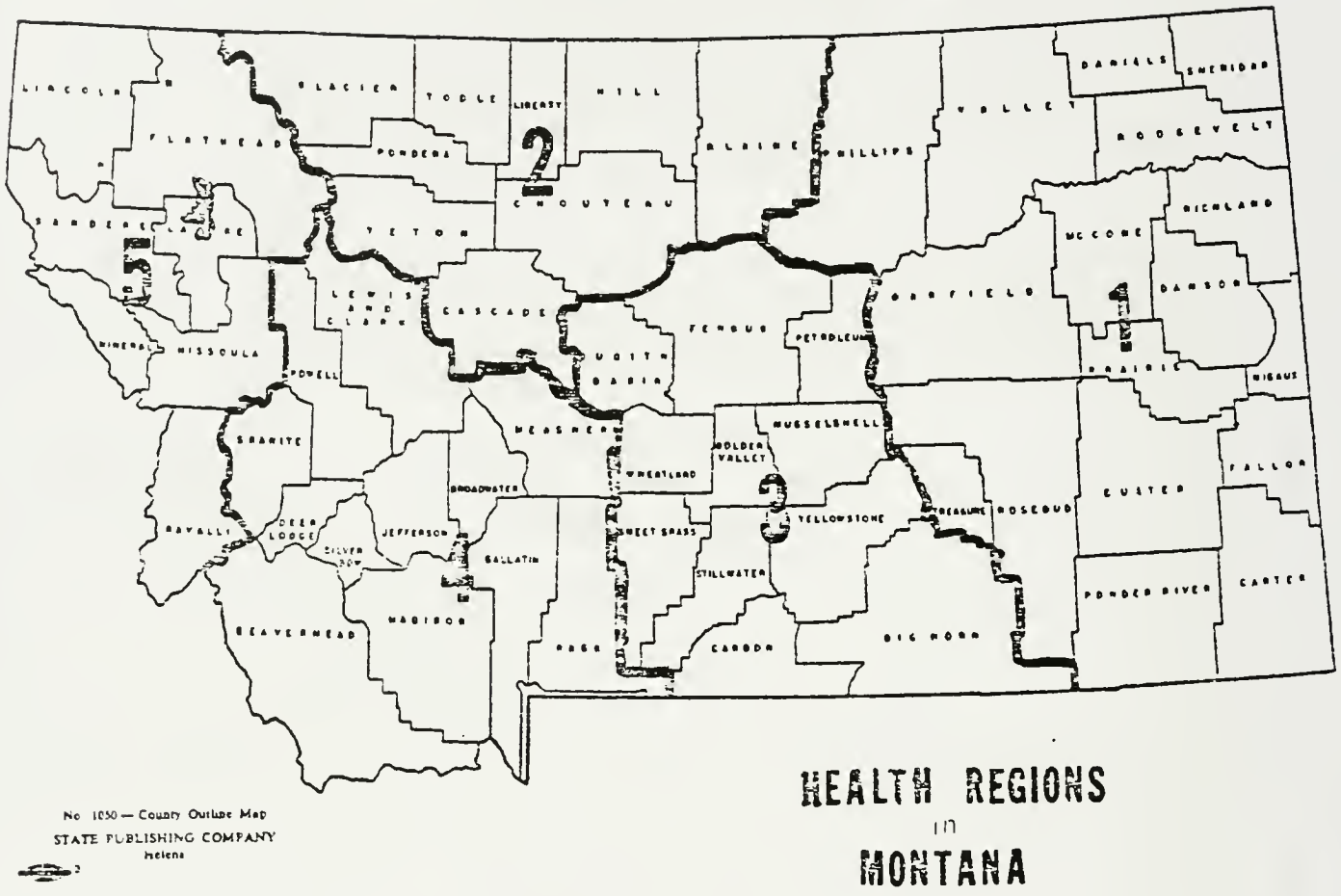
APPENDIX B

MAP AND POPULATION PROJECTIONS BY HEALTH PLANNING DISTRICTS STATE OF MONTANA

MAP AND POPULATION PROJECTIONS

BY HEALTH PLANNING DISTRICTS

STATE OF MONTANA



No. 1050 — County Outline Map

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Helena

HEALTH REGIONS

IN

MONTANA

1970 POPULATION
and
1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY
EASTERN MONTANA (Region 1)

	TOTAL POPULATION			AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1970	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Carter	1,956	1,900	1,882	137	142	433	361	1,059	1,120	271	259
Custer	12,174	12,000	14,642	917	1,212	2,992	3,006	6,593	8,625	1,498	1,791
Daniels	3,083	1,100	3,143	214	259	729	608	1,699	1,803	458	476
Dawson	11,269	10,700	13,067	937	1,156	2,822	2,757	5,954	7,868	987	1,286
Fallon	1,050	4,000	4,326	342	390	1,049	915	2,206	2,549	403	472
Garfield	1,796	1,700	1,781	140	139	410	352	982	1,072	168	221
McCone	2,875	2,700	2,613	211	201	710	532	1,488	1,552	291	328
Phillips	5,386	5,400	5,757	435	471	1,417	1,243	2,830	3,302	718	741
Powder River	2,862	2,400	2,285	207	174	666	499	1,331	1,406	196	206
Prairie	1,752	1,900	1,915	123	140	408	352	1,077	1,092	292	331
Richland	9,837	9,900	12,093	797	998	2,596	2,585	5,407	7,094	1,110	1,416
Roosevelt	10,365	10,300	11,272	1,013	1,005	2,883	2,711	5,399	6,412	1,005	1,144
Rosebud	6,032	9,700	11,230	913	931	2,680	2,809	5,168	6,531	909	959
Sheridan	5,779	5,400	5,144	371	382	1,383	1,011	2,931	2,946	715	805
Treasure	1,069	1,200	1,236	94	105	318	272	653	721	135	138
Valley	11,471	13,200	16,325	1,160	1,391	3,700	3,935	7,297	9,858	1,043	1,141
Wibaux	1,465	1,500	1,538	121	135	386	319	806	892	187	192
TOTALS	93,221	97,000	110,252	8,162	9,231	25,582	24,259	52,880	64,848	10,196	11,914

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, August, 1977. (Medium Series)

1970 POPULATION
and
1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY
NORTH CENTRAL MONTANA (Region 11)

	TOTAL POPULATION			AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1970	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Blaine	6,727	6,800	7,191	617	631	1,827	1,639	3,603	4,191	753	730
Cascade	81,804	83,900	88,274	7,668	8,195	21,061	19,503	47,921	52,875	7,250	7,701
Chouteau	6,473	6,300	6,491	496	551	1,540	1,114	3,503	3,845	761	781
Glacier	10,783	11,100	11,961	1,188	1,041	3,361	3,142	5,635	6,631	916	1,147
Hill	17,358	17,900	19,641	1,552	1,694	4,392	4,046	10,389	11,960	1,567	1,941
Liberty	2,359	2,500	2,697	190	228	671	562	1,421	1,636	218	271
Pondera	6,611	6,900	7,462	583	647	1,868	1,673	3,718	4,329	731	813
Teton	6,116	6,500	7,875	458	610	1,659	1,710	3,582	4,621	801	934
Toole	5,839	5,400	5,174	398	412	1,416	1,079	2,994	3,048	592	615
TOTALS	144,070	147,300	156,766	13,150	14,009	37,795	34,668	82,766	93,136	13,589	14,953

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, August, 1977. (Medium Series)

1970 POPULATION
and
1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY
SOUTH CENTRAL MONTANA (Region III)

COUNTY	TOTAL POPULATION			AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
	1970	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Big Horn	10,057	10,900	12,161	1,221	1,055	3,138	3,162	5,780	7,053	761	891
Carbon	7,080	7,800	8,889	495	672	1,734	1,796	4,213	5,030	1,358	1,411
Fergus	12,611	13,000	13,617	927	1,040	3,232	2,705	6,892	7,811	1,949	2,061
Golden Valley	911	900	917	59	70	188	160	510	534	143	153
Judith Basin	2,667	2,700	2,745	193	233	646	531	1,445	1,580	416	451
Musselshell	3,734	4,200	4,796	297	371	963	1,008	2,292	2,761	648	654
Petroleum	675	700	678	48	50	178	144	425	435	49	49
Stillwater	4,632	5,200	6,090	351	472	1,241	1,299	2,874	3,533	744	795
Sweet Grass	2,980	1,000	2,897	210	221	630	540	1,628	1,657	532	429
Wheatland	2,529	2,400	1,923	165	126	557	347	1,309	1,096	469	354
Yellowstone	87,167	97,000	126,106	7,916	10,456	24,383	28,134	56,961	76,914	8,020	10,602
TOTALS	135,263	148,100	180,819	11,902	14,768	36,880	39,817	84,329	108,334	14,989	17,900

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, August, 1977. (Medium Series)

1970 POPULATION
and
1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY
SOUTHWESTERN MONTANA (Region IV)

	TOTAL POPULATION			AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1970	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Beaverhead	8,187	8,300	9,095	699	868	1,849	1,798	4,862	5,485	890	944
Broadwater	2,526	2,800	3,428	206	287	732	771	1,524	2,002	338	368
Deer Lodge	15,652	15,200	15,482	1,144	1,245	3,482	2,991	8,630	9,071	1,944	2,175
Gallatin	32,505	37,300	44,058	2,851	3,527	7,128	7,342	24,304	29,510	3,017	3,679
Granite	2,737	2,700	2,801	206	236	638	564	1,528	1,600	328	401
Jefferson	5,238	6,700	8,169	539	684	1,724	1,869	3,844	4,948	593	668
Lewis & Clark	33,281	36,900	46,931	3,008	3,865	9,247	10,526	21,020	28,090	3,625	4,450
Madison	5,014	5,800	5,556	396	422	1,367	1,072	3,163	3,223	874	839
Meagher	2,122	2,300	2,216	174	173	527	429	1,327	1,326	272	288
Park	11,197	12,100	14,590	839	1,143	2,778	3,088	6,768	8,472	1,715	1,887
Powell	6,660	7,500	9,015	568	729	1,865	1,983	4,373	5,571	694	732
Silver Bow	41,981	43,000	44,457	3,422	3,581	10,618	9,335	23,847	26,555	5,113	4,936
TOTALS	167,100	180,600	205,798	14,052	16,760	41,955	41,768	105,190	125,853	19,403	21,417

SOURCE: Montana Population Projections 1975 - 2000 Division of Research & Information Systems, Montana Department of Community Affairs, August, 1977. (Medium Series)

1970 POPULATION
and
1975 & 1985 POPULATION PROJECTIONS BY AGE GROUP & COUNTY
NORTHWESTERN MONTANA (Region V)

	TOTAL POPULATION			AGE 0 - 4		AGE 5 - 17		AGE 18 - 64		AGE 65 +	
COUNTY	1970	1975	1985	1975	1985	1975	1985	1975	1985	1975	1985
Flathead	39,460	44,600	56,402	3,611	4,679	11,751	12,791	24,640	33,309	4,598	5,623
Lake	11,445	17,100	19,876	1,425	1,603	4,434	4,551	8,906	11,210	2,335	2,512
Lincoln	18,063	16,500	16,589	1,433	1,285	4,587	3,641	9,334	10,108	1,146	1,567
Mineral	2,958	3,500	4,325	295	373	972	1,036	1,967	2,610	266	306
Missoula	58,263	64,600	78,171	5,106	6,240	14,317	14,404	40,199	51,370	4,978	6,157
Ravalli	14,409	18,400	21,142	1,321	1,630	4,532	4,483	9,728	11,886	2,828	3,143
Sanders	7,093	8,100	9,588	615	750	2,061	2,141	4,350	5,539	1,074	1,158
TOTALS	154,691	172,800	206,093	13,806	16,560	42,648	43,040	99,124	126,032	17,222	20,461

SOURCE: Montana Population Projections 1975 - 2000, Division of Research & Information Systems, Montana Department of Community Affairs, August, 1977. (Medium Series)

APPENDIX C

A GERIATRIC FUNCTIONAL RATING SCALE TO DETERMINE THE NEED FOR INSTITUTIONAL CARE

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A Geriatric Functional Rating Scale to Determine the Need for Institutional Care

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Montreal and Ottawa, Canada

ABSTRACT: This study was carried out to validate a rating scale which could serve as a guide in determining the need for institutional care. The scale assesses the subject's physical and mental disability, balanced against his ability to function and the support available from relatives and community resources. Cut-off points were tested by the use of an 18-month follow-up interval. Initially, 130 aged men and women from three different settings were rated. At the time of follow-up eighteen months later, 83 per cent of the subjects who had obtained an initial score indicative of their inability to function in the community were either dead or in an institution. In contrast, 90 per cent of those who obtained an initial score indicating that they were able to continue in the community, were not in an institution at the time of follow-up. The rating scale can be used not only to help decide the need for institutional care, but also to help determine the most suitable setting for the patient if placement is necessary.

This study is an attempt to demonstrate and validate a functional rating scale which could serve as a practical guide to determine the need for institutional care of aged persons in an urban setting.

At present, 7 per cent of our geriatric population in Canada is living in old people's homes, nursing homes and mental hospitals. It is well known that premature admission to an institution often results in severe regression with accompanying depression and loss of physical and mental functioning. Nevertheless, if admission is unrealistically delayed the patient may have a great deal of difficulty adapting to the institutional setting, which in turn causes increased morbidity and mortality. Goldfarb (1), in his studies of predicted mortality, showed that the relatively healthy aged live longer in settings which contribute to personal comfort, pleasure and maintenance of dignity. The question of placement is often further complicated by the decision of where, or in which setting to institutionalize. The setting is often dictated by the resources available in a community rather than by the needs of the patient. Recently, however, the available facilities have increased so that in certain communities there is now a limited choice. Admission to an institution may be prompted by a life crisis and by pressure from relatives, the patient's physician or police officers. The decision to place a patient is often left in the hands of inexperienced professionals. However, Blenkner (2) found that, even if trained professionals are employed, institutional placement and morbidity occur sooner and more frequently in a group receiving "professional social work services" than in a matched group receiving few or no social services. The explanation could be that even an experienced professional sometimes is influenced by emotional bias to institutionalize patients prematurely.

Thus it appeared that a rating scale could serve as a practical guide for determining more accu-

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C–2

rately and objectively the proper need for placement, and also aid in the choice of the appropriate institutional setting.

Our rating scale was structured in the Day Hospital of Maimonides Hospital and Home for the Aged in Montreal. The primary purpose of the Day Hospital is to support patients as long as possible in the community in an attempt to avoid admission as inpatients. The multidisciplinary approach and experience helped in the development of the rating scale.

We first attempted to rate the patient's degree of physical and emotional well-being. There is, however, no single index for measuring a person's health. "Health anxiety" can cause severe discrepancies between subject and doctor assessments. This difficult type of rating can be done accurately only by a medically trained professional. Nevertheless, many rating scales which measure physical and emotional disability have been developed and used in geriatrics (3, 4). Yet there is always the problem of weighing a disability in one area against ability in another area, e.g., blindness against the ability to walk. Rating the ability to care for oneself has therefore been accepted as the best way to assess physical and mental functioning in the elderly. Katz et al (5), Lowenthal (6) and Lawton and Brody (7) developed ADL (activities of daily living) scales which are widely used to assess the ability of individuals to look after themselves or to rate their degree of independence. Other factors, however, also play a role in maintaining an aged person in the community.

The rating scale which we developed combines the assessment of physical and mental disability with the assessment of ability to function. It also takes into account such factors as support from relatives and friends, the patient's financial situation and living arrangements, and the availability of various community resources (e.g., recreational facilities and Meals-on-Wheels services). In this fashion, we are able to make a global assessment of a person's ability to maintain himself in the community.

Physical and mental disability are given minus values; the ability to function and the support measures are given plus values. A "final score" consisting of the sum of the minus and plus scores is obtained for each person rated. The accompanying Chart shows the rating scale. The information sheet for raters can be obtained on request.

In order to validate our rating scale and to establish the various cut-off points, we undertook a small pilot study of three different groups: 1) members of the Golden Age Association in Montreal, 2) patients applying for admission or being treated in the Day Hospital at Maimonides Hospital and Home for the Aged, and 3) patients evaluated for help or possible institutional admission by the Geriatric Service of the Royal Ottawa Hospital in Ottawa, Ontario. These three groups would naturally show an increasing degree of disability and inability to function in their respective communities. The initial ratings were carried out respectively by volunteer social work students, by a nurse and social worker in the Day Hospital, and by a visiting nurse. An information sheet or guide was supplied for the use of the raters in order to standardize the results. After a time interval, we undertook a follow-up study. Only patients successfully followed are included in this report. The approximate time lapse between the rating date and follow-up date was eighteen months.

RESULTS

Table 1 shows the demographic data and average ratings for the three groups. As could be predicted on the basis of the composition of the groups, the average score was highest for the Golden Age Association members and lowest for the Ottawa patients.

At the onset of the study we established three categories based on the degree of independence or ability to continue outside an institutional setting, as indicated by the rating score. The raters were not aware of these categories:

1. Persons with a score above 40 would be those who were able to live in their own home setting; they did not need to enter an institution.
2. A score between 20 and 40 indicated that the person required some supportive care but not placement in a nursing home. He or she could probably function in a supervised

TABLE 1
Demographic Data and Average Ratings for the 3 Groups of Subjects

Group	No. of Subjects	Sex		Avge. Age (yrs.)	Avge. Rating Score
		Male	Female		
Golden Age	49	16	33	74	72
Day Hospital	35	15	20	71	55
Ottawa	46	18	28	72	2
Totals	130	49	81		

GERIATRIC FUNCTIONAL RATING SCALE

NAME _____ Date of Birth _____

ADDRESS _____ Tel. No. _____

Sex: M F Marital Status: Si M W D S Rel: H P C O

Relative or Friend:

Name _____

Address _____ Tel. No. _____

1/ PHYSICAL CONDITION		Score		Score		Score
A) Eyesight	Good Watches TV Reads Needlework	0	Distinguishes Faces	-3	Sees Light only	-10
B) Hearing	Good	0	Loud Voice	-3	Deaf	- 5
C) Mobility	Fully Mobile - Dresses Carries Parcels Rides Bus	0	Uses Cane or should use one Dependent on railings	-3	Requires Cane & other support - Wheelchair	-15
D) Pulmo-Cardio-Vascular Function	No Restrictions	0	1 Flight of Stairs 1 City Block	-3	Partly or totally Bedridden	-20
E) Diet	No Restrictions	0			Yes	- 3

2/ MENTAL CONDITION		Score		Score		Score
A) Disorientation	None	0	Time	-3	Person &/or Place	-15
B) Delusions	None	0	Mild - Severe Suspiciousness	-3	Overt	-10
C) Memory Loss	None	0	Benign	-3	Malignant	-20
D) Energy & Drive	Normal	0			Hypoactive or Hyperactive	- 5
E) Judgment	Intact	0			Impaired	- 5
F) Hallucinations	None	0			Auditory &/or Visual	-10

boarding home, an institution providing domiciliary care (e.g., a veterans' lodge), an apartment hotel, or even an apartment project for senior citizens with built-in support measures. A day care program could also be used to provide additional support for the patient and his family while the patient lived in a protective setting or in the community. Some patients were rated while attending a day hospital.

3. A score under 20 indicated that the patient required care in a nursing home or chronic disease hospital, or placement in a psychiatric facility when his or her psychiatric condition made management in other settings impossible.

3/ FUNCTIONAL ABILITIES		Score
A)	Reads and writes letters	+ 2
B)	Able to use telephone	+ 5
C)	Able to bank and shop	+ 5
D)	Able to prepare simple meals and bake	+ 7
E)	Washes, dresses and toilets self without assistance	+ 5
F)	Uses public transportation	+ 7
G)	Able or would be able to take own medication and follow diet	+ 10

4/ SUPPORT FROM THE COMMUNITY		Score
A)	Ethnic compatibility	+ 2
B)	If living alone, can get support and help from a reliable relative, friend, neighbour, janitor	+ 10
C)	Able to shop at reliable grocer's (willing to deliver when necessary)	+ 5
D)	Available supportive and recreational facilities -	
	- Clubs geared to aged	+ 2
	- Church, synagogue	+ 1
	- Library	+ 1
	- Park, shopping center, restaurant, movies	+ 1
E)	Geographic availability of - Public health nurses	+ 2
	- Meals-on-Wheels service	+ 2
	- Homemaker services	+ 2
	- Friendly visitor	+ 2
	- Hospital with emergency and clinic facilities	+ 2
	- Public transportation	+ 2

5/ LIVING QUARTERS		Score
	Elevator service or living on ground floor or basement	+ 3

6/ RELATIVES AND FRIENDS		Score
A)	Not married but lives with compatible and helpful relative or friend	+ 5
B)	Lives with incompatible relative, friend or spouse	0
C)	Lives with able and compatible spouse	+ 10

7/ FINANCIAL SITUATION		Score
A)	Totally independent	+ 5
B)	Dependent on helpful relative	+ 3
C)	Dependent mainly on Old Age Pension &/or other comm.resources	0

Total Plus Score _____

Total Minus Score _____

Final Score _____

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Table 2 shows an analysis according to the score obtained on the test and the outcome after an 18-month follow-up. Of the 36 patients who obtained a score below 19, 30 or 83 per cent were in an institution or dead at the time of follow-up. Nine of the 14 deceased patients had a score below 19. The low scores of these debilitated patients are further proof of the validity of our rating scale. Of the 77 aged whose score was above 40, 69 or 90 per cent were living in the community after an 18-month time lapse.

The validity of the scale is less accurate when assessing the need for a protective setting. Of 17 subjects with an initial 20–39 score, 7 were living in a "protective setting" on follow-up.

On reviewing the cases that did not fit into the predicted categories, one realizes that the onset of a sudden physical illness makes prediction impos-

TABLE 2
Follow-up in Relation to Predicted Outcome, 18 Months after Initial Rating

Initial Scores	Living in Community	Living in Protective Setting	In Institution	Deceased	Total
Under 19	5	1	21	9	36
20–39	5	7	2	3	17
40+	69	2	4	2	77
Totals	79	10	27	14	130

sible. Three patients who had scores over 40 were in an institution at the time of follow-up because of a cerebrovascular accident. This could not be predicted on the initial rating.

In 3 other cases in which the scores were below 19, financial resources or an able spouse delayed institutional admission. In another case, ample financial means prompted premature admission to an institution to insure the "comfort" of the patient.

COMMENT

This study demonstrates the use of a rating scale to determine the need for institutional admission. Initially, 130 subjects were rated. After an 18-month interval, the predictions made at the time of the initial rating held up well in many instances. The follow-up study has already prompted certain revisions in the rating scale which we hope will increase the accuracy of our predictions.

Our experience indicates that a rating scale can be a very useful instrument to help in deciding the need for admission to an institution and in determining the most suitable setting for the patient if placement is necessary.

Acknowledgments

The authors gratefully acknowledge the assistance of Mrs. Florence Kirshner, Golden Age Association of Montreal, and of Dr. Stanley Goldstein, Royal Ottawa Hospital, Ottawa.

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APPENDIX K

CERTIFICATIONS
&
REPRESENTATIONS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REPRESENTATIONS AND CERTIFICATIONS

Representations

1. Type of Organization.
2. Employer's Identification Number.
3. Small Business.
4. Minority Business Enterprise.
5. Woman-Owned Business.
6. Regular Dealer - Manufacturer.
7. Contingent Fee.
8. Percent of Foreign Content.

Certifications

9. Equal Opportunity.
10. Nonsegregated Facilities.
11. Buy American.
12. Duplication of Cost.
13. Place of Performance.
14. Independent Price Determination.
15. Cost Accounting Standards - Nondefense Applicability
16. Clean Air and Water.
17. Current Cost or Pricing Data.

To Be Completed by Offeror:

The offeror makes the following Representations and Certifications as part of its proposal (check or complete all appropriate boxes or blanks on the following pages).

STATE OF MONTANA
DEP'T. OF SOCIAL & REHABILITATION SERVICES — (Name of Offeror)

74-80-HEW-OS — (RFP No.)

Keith L. Colbo — (Signature)

June 9, 1980 — (Date)

Keith L. Colbo, Director
(Typed Name of Authorized Individual)

Note: The penalty for making false statements in offers is prescribed in 18 U.S.C. 1001.

1. TYPE OF ORGANIZATION

The offeror operates as an ( ) individual, (x) state or local agency, ( ) partnership, ( ) joint venture, ( ) nonprofit, ( ) educational institution, ( ) corporation organized and existing under the laws of the State of _____.

2. EMPLOYER's IDENTIFICATION NUMBER

The offeror's Internal Revenue Service "Employer's Identification Number" is State of Montana . 81-0302402

3. SMALL BUSINESS REPRESENTATIONS

This firm ( ) is, (x) is not, a small business concern. If the firm is a small business concern and is not the manufacturer of the supplies to be furnished hereunder, the firm also represents that all such supplies ( ) will, ( ) will not, be manufactured or produced by a small business concern in the United States, its possessions, or Puerto Rico. (A small business concern for the purpose of Government procurement is a concern, including its affiliates, which is independently owned and operated, is not dominant in the field of operation in which it is contracting and can further qualify under the criteria concerning number of employees, average annual receipts, or other criteria, as prescribed by the Small Business Administration.) (See Code of Federal Regulations, Title 13, Part 121, as amended, which contains detailed definitions and related procedures.)

4. MINORITY BUSINESS ENTERPRISE

The offeror represents that it ( ) is, (x) is not, a minority business enterprise. A minority business enterprise is defined as a "business, at least 50 percent of which is owned by minority group members or, in case of publicly owned businesses, at least 51 percent of the stock of which is owned by minority group members". For the purpose of this definition, minority group members are Negroes, Spanish-speaking American persons, American-Orientals, American-Indians, American-Eskimos, and American-Aleuts.

5. WOMAN-OWNED BUSINESS

The firm ( ) is, (x) is not, a woman-owned business. A woman-owned business is a business which is, at least, 51 percent owned, controlled, and operated by a woman or women. Controlled is defined as exercising the power to make policy decisions. Operated is defined as actively involved in the day-to-day management.

For the purposes of this definition, businesses which are publicly owned, joint stock associations, and business trusts are exempted. Exempted businesses may voluntarily represent that they are, or are not, women-owned if this information is available.

6. REGULAR DEALER - MANUFACTURER REPRESENTATION

(Applicable only to supply contracts exceeding $10,000.) N/A

The offeror is a ( ) regular dealer in, ( ) manufacturer of, the supplies covered by this proposal.

7. CONTINGENT FEE REPRESENTATION

(Applicable only to proposals in which the aggregate amount involved exceeds $10,000.)

Offeror represents (a) that it ( ) has, (X) has not, employed or retained any company or person (other than a full-time bona fide employee working solely for the offeror) to solicit or secure this contract, and (b) that it ( ) has, (X) has not, paid or agreed to pay any company or person (other than a full-time bona fide employee working solely for the offeror) any fee, commission, percentage or brokerage fee, contingent upon or resulting from the award of this contract; and agrees to furnish information relating to (a) and (b) above as requested by the Contracting Officer.

(Note: For interpretation of representation, including the term "bona fide employee", see Code of Federal Regulations, Title 41, Chapter 1, Subpart 1-1.5.)

8. PERCENT OF FOREIGN CONTENT

The offeror/contractor will represent (as an estimate), immediately after the award of a contract, the percent of the foreign content of the item or service being procured expressed as a percent of the contract award price (accuracy within plus or minus 5 percent is acceptable). N/A

9. EQUAL OPPORTUNITY CERTIFICATION

The bidder (or offeror) (X) has, ( ) has not, participated in a previous contract or subcontract subject either to the Equal Opportunity clause herein or the clause originally contained in section 301 of Executive Order No. 10925, or the clause contained in Section 201 of Executive Order No. 11114; that it (X) has, ( ) has not, filed all required

compliance reports; and that representations, indicating submission of required compliance reports, signed by proposed subcontractors, will be obtained prior to subcontract awards. (The above representation need not be submitted in connection with contracts or subcontracts which are exempt from the equal opportunity clause.)

The bidder (or offeror) represents that (1) it (X) has developed and has on file, ( ) has not developed and does not have on file, at each establishment affirmative action programs as required by the rules and regulations of the Secretary fo Labor (41 CFR 60-1 and 60-2) or (2) it (X) has, ( ) has not previously had contracts subject to the written affirmative action programs requirement of the rules and regulations of the Secretary of Labor. (The above representations shall be completed by each bidder (or offeror) whose bid (offer) is $50,000 or more and who has 50 or more employees.)

10. CERTIFICATION OF NONSEGREGATED FACILITIES

By the submission of this offer, the offeror or subcontractor certifies that it does not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained. It certifies further that it will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it will not permit its employees to perform their services at any location, under its control, where segregated facilities are maintained. The offeror or subcontractor agrees that a breach of this certification is a violation of the Equal Opportunity Clause of this contract. As used in this certification, the term "Segregated Facilities" means any waiting room, work areas, rest rooms and wash rooms, restaurants and other eating areas, time clocks, locker rooms and other storage or dressing areas, parking lots, drinking fountains, recreation or entertainment areas, transportation and housing facilities provided for employees which are segregated by explicit directive or are in fact segregated on the basis of race, creed, color, or national origin, because of habit, local custom, or otherwise. It further agrees that (except where he has obtained identical certifications from proposed subcontractors for specific time periods) it will obtain identical certifications from proposed subcontractors prior to the award of subcontracts exceeding $10,000.00 which are not exempt from the provisions of the Equal Opportunity Clause; that it will retain such certifications in its files; and that it will forward the

following notice to such proposed subcontractors (except where the proposed subcontractors have submitted identical certifications for specific time periods).

Notice to Prospective Subcontractors of Requirement for Certifications of Nonsegregated Facilities

A Certification of Nonsegregated Facilities, as required by the May 9, 1967, order (32 F.R. 7439, May 19, 1967) on Elimination of Segregated Facilities, by the Secretary of Labor, must be submitted prior to the award of a subcontract exceeding $10,000 which is not exempt from the provisions of the Equal Opportunity Clause. The certification may be submitted either for each subcontract or for all subcontracts during a period (i.e., quarterly, semi-annually or annually).

Note: Failure of an offeror to agree to the Certification of Nonsegregated Facilities shall render its offer nonresponsive to the terms of solicitations involving awards of contracts exceeding $10,000 which are not exempt from the provisions of the Equal Opportunity Clause.

11. BUY AMERICAN CERTIFICATE

(Applies to proposals involving end products as defined by FPR 1-6.101.)

The offeror hereby certifies that each end product, except the end product listed below, is a domestic source end product (as defined in the clause entitled, "Buy American Act"), and that components of unknown origin have been considered to have been mined, produced, or manufactured outside the United States:

Excluded end products (show country of origin for each excluded end product).

_____

_____

12. DUPLICATION OF COST

The Contractor represents and certifies that any charges contemplated and included in its estimate of cost for performance are not duplicative of any charges against any other Government contract, subcontract, or other Government source.

13. PLACE OF PERFORMANCE

Following is the name and location of the plant or place of business where the item(s) will be produced or supplied from stock or where the service will be performed.

Montana Department of Social & Rehabilitation Services
(Name of Plant)

Helena, Montana 59601
(City and State)

Lewis & Clark, Congressional District # 1
(County and Congressional District)

14. CERTIFICATION OF INDEPENDENT PRICE DETERMINATION

a. By submission of this proposal, each offeror certifies and in the case of a joint bid or proposal, each party thereto certifies as to its own organization, that in connection with this procurement:

(1) The prices in this proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other offeror or with any competitor;

(2) Unless otherwise required by law, the prices which have been quoted in this proposal have not been knowingly disclosed by the offeror and will not knowingly be disclosed by the offeror prior to award directly or indirectly to any other offeror or to any competitor; and,

(3) No attempt has been made or will be made by the offeror to induce any other person or firm to submit or not to submit a proposal for the purpose of restricting competition.

b. Each person signing this bid or proposal certifies that:

(1) He/she is the person in the offeror's organization responsible within that organization for the decision as to the prices being offered herein and that he/she has not participated, and will not participate, in any action contrary to (a)(1) through (a)(3) above; or,

(2) That (a) he/she is not the person in the offeror's organization responsible within that organization for the decision as to the prices being offered herein but that he/she has been authorized in writing to act as agent for the persons responsible for such decision in certifying that such persons have not participated, and will not participate, in any action contrary to (a)(1) through (a)(3) above, and as their agent does hereby so certify; and (b) he/she has not participated in any action contrary to (a)(1) through (a)(3) above.

c. This certification is not applicable to a foreign offeror submitting a proposal for a contract which requires performance or delivery outside the United States, its possessions, and Puerto Rico.

d. A proposal will not be considered for award where (a)(1), (a)(3), or (b) above has been deleted or modified. Where (a)(2) above has been deleted or modified, the proposal will not be considered for award unless the offeror furnishes with the proposal a signed statement which sets forth in detail the circumstances of the disclosure and the head of the agency, or its designee, determines that such disclosure was not made for the purpose of restricting competition.

15. COST ACCOUNTING STANDARDS - CERTIFICATION - NONDEFENSE APPLICABILITY

(Certification Number 15 is not applicable to solicitations: (1) where the price is based on established catalog or market prices of commercial items sold in substantial quantities to the general public; (2) where the price is set by law or regulation; (3) sent to the Canadian Commercial Corporation; and, (4) where the resulting contract will be executed and performed in their entirety outside the United States, its teritories and possessions.)

Any negotiated contract in excess of $100,000 resulting from this solicitation shall be subject to the requirements of the clauses entitled Cost Accounting Standards--Nondefense Contract (FPR 1-3.1204-2(a)) and Administration of Cost Accounting Standards (FPR 1-3.1204-1(b)) if it is awarded to a contractor's business unit that is performing a national defense contract or subcontract which is subject to cost accounting standards (CAS) pursuant to 4 CFR 331 at the time of award, except contracts which are otherwise exempt (See FPR 1-3.1203-2(a) and (c)(4)). Otherwise, an award resulting from this solicitation shall be subject

to the requirements of the clauses entitled Consistency of Cost Accounting Practices--Nondefense Contract (FPR 1-3.1204-2(b)) and Administration of Cost Accounting Standards (FPR 1-3.1204-1(b)), if the award is (i) the first negotiated contract over $500,000 in the event the award is to a contractor's business unit that is not performing under any CAS covered national defense or nondefense contract or subcontract, or (ii) a negotiated contract over $100,000 in the event the award is to a contractor's business unit that is performing under any CAS covered national defense or nondefense contract or subcontract, except contracts which are otherwise exempt (See FPR 1-3.1203-2(a) and (c)(4)). This solicitation notice is not applicable to small business concerns.

Certificate of CAS Applicability

The Offeror hereby certifies that:

(a) ( ) It is currently performing a negotiated national defense contract or subcontract that contains CAS Clause (4 CFR Part 331), and it is currently required to accept that clause in any new negotiated national defense contracts it receives that are subject to CAS.

(b) ( ) It is currently performing a negotiated national defense or nondefense contract or subcontract that contains a CAS Clause required by 4 CFR Part 331 or 332 or by FPR Subpart 1-3.12, but it is not required to accept the 4 CFR 331 Clause in new negotiated national defense contracts or subcontracts which it receives that are subject to CAS.

(c) ( ) It is not performing any CAS covered national defense or nondefense contract or subcontract. The offeror further certifies that it will immediately notify the Contracting Officer in writing in the event that it is awarded any negotiated national defense or nondefense contract or subcontract containing any CAS Clause subsequent to the date of this certificate but prior to the date of the award of a contract resulting from this solicitation.

(d) ( ) It is an educational institution receiving contract awards subject to FPR Subpart 1-15.3 (FMC 73-8, OMB Circular A-21).

16. CLEAN AIR AND WATER CERTIFICATON

(Applicable if the bid or offer exceeds $100,000 or the Contracting Officer has determined that orders under an indefinite quantity contract in any year will exceed $100,000, or a facility to be used has been the subject of a conviction under the Clean Air Act (41 U.S.C. 1857C-8(C)(1)), or the Federal Water Pollution Control Act (33 U.S.C. 1319(c)) and is listed by EPA, or is not otherwise exempt.) The bidder or offeror certifies as follows:

(a) Any facility to be utilized in the performance of this proposed contract has ( ), has not (x), been listed on the Environmental Protection Agency list of violating facilities.

(b) It will promptly notify the Contracting Officer, prior to award, of the receipt of any communication from the Director, Office of Federal Activities, Environmental Protection Agency, indicating that any facility which it proposes to use for the performance of the contract is under consideration to be listed on the EPA list of violating facilities.

(c) It will include substantially this certification, including this paragraph (c), in every non-exempt subcontract.

17. CERTIFICATE OF CURRENT COST OR PRICING DATA

When a certificate of cost or pricing data is required to be submitted in accordance with Federal Procurement Regulations (FPR) 1-3.807-3, the Contracting Officer will request that the offeror complete, execute, and submit to the Contracting Officer a certificaton in the format shown in the following Certificate of Current Cost or Pricing Data. The certification shall be submitted only at the time negotiations are concluded. Offerors should complete the certificate set forth below and return it when requested by the Contracting Officer.

CERTIFICATE OF CURRENT COST OR PRICING DATA

This is to certify that to the best of my knowledge and belief, cost or pricing data* submitted in writing or specifically identified in writing if actual submission of the

* Approved Cost Allocation Plan to the State from HEW

(e) (x) It is a State or local government receiving contract awards subject to FPR Subpart 1-15.7 (FMC 74-4, OMB Circular A-87).

(f) ( ) It is a hospital.

Note: Certain firm fixed price negotiated nondefense contracts awarded on the basis of price competition may be determined by the Contracting Officer (at the time of award) to be exempt from CAS (FPR 1-3.1203-2 (c)(4)(iv)).

Additional Certification --
CAS Applicable Offerors

(g) ( ) The offeror, subject to CAS but not certifying under (d), (e), or (f) above, further certifies that practices used in estimating costs in pricing this proposal are consistent with the practices disclosed in the Disclosure Statement(s) where they have been submitted pursuant to CAS regulations (4 CFR Part 351).

Data Required -- CAS
Covered Offerors

The offeror certifying under (a) or (b) above, but not under (d), (e), or (f) above, is required to furnish the name, address (including agency or department component), and telephone number of the cognizant Contracting Officer administering the offeror's CAS covered contracts. If (a) above is checked, the offeror will also identify those currently effective CAS, if any, which upon award of the next negotiated national defense contract or subcontract will become effective upon the offeror.

Name of Contracting Officer_____

Address_____

_____

Telephone Number_____

Standards Not Yet Applicable_____

_____

SUMMARY

This Request for Proposals (RFP) seeks up to nine (9) contractors to implement demonstration projects associated with the NATIONAL CHANNELING DEMONSTRATION PROGRAM. The channeling program is intended to meet a current need of the government by producing information that will lead to administrative and legislative initiatives for developing a more effective long-term care system. The term "channeling" is defined as the organizational structures and operating systems required in a community to link people who need long-term care to the appropriate services. At the core of channeling is client assessment and case management as methods for organizing care to meet individual needs and controlling long-term care expenditures.

The Department has established the following purposes for the national program:

1. To stimulate improvements at the state and community level in the organization and orientation of the long-term care delivery system, the relationships between service providers, and the way long-term care resources are distributed and controlled.

2. To demonstrate and measure the effectiveness of various channeling approaches for managing long-term care resources within a community on behalf of individual clients.

3. To collect comparable information on the impact of channeling on costs, services utilization and client outcomes to assist the Department, states and communities in the development of more humane and effective long-term care policies.

4. To develop a greater understanding of the population who needs and uses long-term care.

For fiscal year 1980, the Congress has appropriated $20.5 million to fund channeling demonstration projects and associated activities. Demonstration projects are expected to be funded for a period of five years, based on the continued availability of federal funds, satisfactory project performance and the Department's evaluation needs.

A. Program Components

The Department is implementing four (4) related components of the National Channeling Demonstration Program in fiscal year 1980.

The first component, the development and implementation of up to nine (9) channeling demonstration projects, is the subject of this RFP. In addition, the Department is also issuing the following solicitations for work to be performed under the national program:

data is impracticable (see 1-3.807-3(h)(2)), to the Contracting Officer or representative in support of _____ _____** are accurate, complete, and current as of _____***.
(date)

FIRM_____

NAME Keith F. Colby

TITLE_____

June 9, 1980 ****
(Date of Execution)

---

* For definition of "cost or pricing data", see FPR 1-3.807-3.

** Describe the proposal, quotation, request for price adjustment, or other submission involved, giving appropriate identifying number (e.g., RFP No._____).

*** This date shall be the date when the price negotiations were concluded and the contract price was agreed to. The responsibility of the contractor is not limited by the personal knowledge of the contractor's negotiator if the contractor has information reasonable available (see 1-3.807-5(a)) at the time of agreement showing that the negotiated price is not based on accurate, complete and current data.

**** This date should be as close as practicable to the date when the price negotiations were concluded and the contract price was agreed upon.

ASSURANCE OF PROTECTION OF HUMAN SUBJECTS

"Contractor agrees to comply with all state licensing standards, all applicable federal service standards, and any other standards, procedures, or policies established by the Department in the future to assure quality services. Contractor's compliance specifically includes, but is not limited to, all Department policies and procedures on client rights, confidentiality, experimental techniques, and the use of noxious and aversive stimulation."

FIRM_____

NAME Keith F. Colby

TITLE_____

STATE OF MONTANA

DEPARTMENT OF SOCIAL AND
REHABILITATION SERVICES

CHANNELING DEMONSTRATION PROPOSAL

Business Proposal

Montana's response to RFP-74-80-HEW-OS
National Long-term Channeling Demonstration

SRS BUILDING
111 Sanders Street
Helena, Montana 59601

CONTRACT PRICING PROPOSAL
(RESEARCH AND DEVELOPMENT)

Office of Management and Budget
Approval No. 29-RO184

This form is for use when (i) submission of cost or pricing data (see FPR 1-3.807-3) is required and (ii) substitution for the Optional Form 59 is authorized by the contracting officer.

PAGE NO. | NO. OF PAGES

NAME OF OFFEROR	SUPPLIES AND/OR SERVICES TO BE FURNISHED
Montana Dept. Social & Rehab. Services	National Long-Term Care Channeling Demonstration. Proposal in Response to RFP-74-80-HEW-OS
HOME OFFICE ADDRESS: 111 Sanders St., Helena, Mt 59601	

DIVISION(S) AND LOCATION(S) WHERE WORK IS TO BE PERFORMED	TOTAL AMOUNT OF PROPOSAL	GOV'T SOLICITATION NO.
Montana demonstration site	$ 2,440,165	RFP-74-80-HEW-OS

DETAIL DESCRIPTION OF COST ELEMENTS

			EST COST ($)	TOTAL EST COST[1]	REFERENCE[2]
1. DIRECT MATERIAL *(Itemize on Exhibit A)*					
a. PURCHASED PARTS					
b. SUBCONTRACTED ITEMS					
c. OTHER—(1) RAW MATERIAL					
(2) YOUR STANDARD COMMERCIAL ITEMS					
(3) INTERDIVISIONAL TRANSFERS *(At other than cost)*					
TOTAL DIRECT MATERIAL					
2. MATERIAL OVERHEAD[3] *(Rate %.X's base =)*					
3. DIRECT LABOR *(Specify)*	ESTIMATED HOURS	RATE/HOUR	EST COST ($)		
SRS STATE OFFICE -- COSTS FOR 5 YEARS	15,600	10.38	$161,886		A
TOTAL DIRECT LABOR				161,886	
4. LABOR OVERHEAD *(Specify Department or Cost Center)*[3]	O.H. RATE	X BASE =	EST COST ($)		
SRS CENTRALIZED SERVICES -- HEW APPROVED COST ALLOC. PLAN			30,526		A
TOTAL LABOR OVERHEAD				30,526	
5. SPECIAL TESTING *(Including field work at Government installations)*			EST COST ($)		
SUBCONTRACT --SITE--CHANNELING AGENCY--COSTS FOR 5 YEARS			1,001,690		A
TASK 5--SERVICE EXPANSION--5 YEARS			1,050,000		A
TOTAL SPECIAL TESTING				2,051,690	
6. SPECIAL EQUIPMENT *(If direct charge) (Itemize on Exhibit A)*					
7. TRAVEL *(If direct charge) (Give details on attached Schedule)*			EST COST ($)		
a. TRANSPORTATION					
b. PER DIEM OR SUBSISTENCE					
TOTAL TRAVEL				13,661	A
8. CONSULTANTS *(Identify—purpose—rate)*			EST COST ($)		
SRS TECHNICAL CONSULT.--DEVEL. INFO. SYST.:SCREENING INST.			126,574		A
MONTANA FOUNDATION FOR MEDICAL CARE: SERVICE AUDIT/REVIEW			43,621		A
TOTAL CONSULTANTS				170,195	
9. OTHER DIRECT COSTS *(Itemize on Exhibit A)*					
10. TOTAL DIRECT COST AND OVERHEAD				12,207	A
11. GENERAL AND ADMINISTRATIVE EXPENSE *(Rate % of cost element Nos.)*[3]					
12. ROYALTIES[4]					
13. TOTAL ESTIMATED COST				2,440,165	
14. FEE OR PROFIT					
15. TOTAL ESTIMATED COST AND FEE OR PROFIT				2,440,165	

OPTIONAL FORM 60
October 1971
General Services Administration

ATTACHMENT C

This proposal is submitted for use in connection with and in response to (Describe RFP, etc.)

NATIONAL LONG-TERM CARE CHANNELING DEMONSTRATION. RFP-74-80-HEW-OS

and reflects our best estimates as of this date, in accordance with the Instructions to Offerors and the Footnotes which follow

TYPED NAME AND TITLE	SIGNATURE
Keith L. Colbo, Director,	Keith L. Colbo

NAME OF FIRM	DATE OF SUBMISSION
Montana Department of Social & Rehabilitation Services	June 13, 1980

EXHIBIT A—SUPPORTING SCHEDULE *(Specify. If more space is needed, use reverse)*

COST EL NO	ITEM DESCRIPTION *(See footnote 5)*	EST COST ($)
	EXHIBIT A IS ON THE ATTACHED SHEETS	
	Beginning with a Pricing Summary	
	Followed by Pricing details grouped by tasks	
	Followed by time chart of activities and person hours by month from date of contract.	
	NOTICE: THE OFFEROR SUBMITS AN ALTERNATE, ENCLOSED IN THIS COVER, BUT SEPARATE FROM THIS REQUEST FOR PROPOSALS.	
	NOTICE: THIS OFFER DOES NOT INCLUDE ANY COSTS ASSOCIATED WITH TASK 9. IT IS THE OFFEROR'S UNDERSTANDING THAT SHOULD THE GOVERNMENT EXERCISE THIS OPTION THAT FUNDS FOR THIS PURPOSE WILL BE ADDED AT THAT TIME. ONE HALF FTE IS SEPARTATELY IDENTIFIED IN PERSON DAY ALLOCATION CHARTS., HOWEVER. THE OFFEROR WILL ARRANGE FOR HIRING AND PURCHASING EQUIPMENT WHEN THE TIME AND MONEY COME.	

I. HAS ANY EXECUTIVE AGENCY OF THE UNITED STATES GOVERNMENT PERFORMED ANY REVIEW OF YOUR ACCOUNTS OR RECORDS IN CONNECTION WITH ANY OTHER GOVERNMENT PRIME CONTRACT OR SUBCONTRACT WITHIN THE PAST TWELVE MONTHS?

☐ YES ☒ NO *(If yes, identify below.)*

NAME AND ADDRESS OF REVIEWING OFFICE AND INDIVIDUAL	TELEPHONE NUMBER/EXTENSION

II. WILL YOU REQUIRE THE USE OF ANY GOVERNMENT PROPERTY IN THE PERFORMANCE OF THIS PROPOSED CONTRACT?

☐ YES ☒ NO *(If yes, identify on reverse or separate page)*

III. DO YOU REQUIRE GOVERNMENT CONTRACT FINANCING TO PERFORM THIS PROPOSED CONTRACT?

☐ YES ☒ NO *(If yes, identify.):* ☐ ADVANCE PAYMENTS ☐ PROGRESS PAYMENTS OR ☐ GUARANTEED LOANS

IV. DO YOU NOW HOLD ANY CONTRACT *(Or, do you have any independently financed (IR&D) projects)* FOR THE SAME OR SIMILAR WORK CALLED FOR BY THIS PROPOSED CONTRACT?

☐ YES ☒ NO *(If yes, identify.)*

V. DOES THIS COST SUMMARY CONFORM WITH THE COST PRINCIPLES SET FORTH IN AGENCY REGULATIONS?

☒ YES ☐ NO *(If no, explain on reverse or separate page)*

See Reverse for Instructions and Footnotes

OPTIONAL FORM 60 (10-71)

EXHIBIT A

MONTANA CHANNELING DEMONSTRATION

ITEM: DIRECT LABOR, including fringe:

Phase I,	Task 1	$ 14,326
	Task 2	$ 4,421
	Task 3	$ 7,694
	Task 4	$ 29,185
Phase II,	Year 3	$ 32,103
	Year 4	$ 35,313
Phase III		$ 38,844
		$ 161,886

ITEM: LABOR OVERHEAD

Phase I,	Task 1	$ 2,700
	Task 2	$ 850
	Task 3	$ 1,450
	Task 4	$ 5,500
Phase II,	Year 3	$ 6,050
	Year 4	$ 6,655
Phase III		$ 7,321
		$ 30,526

ITEM: TRAVEL

Phase I,	Task 1	$ -0-
	Task 2	$ 1,755
	Task 3	$ 1,885
	Task 4	$ 2,159
Phase II,	Year 3	$ 2,375
	Year 4	$ 2,613
Phase III		$ 2,874
		$ 13,661

ITEM: SPECIAL TESTING--SUBCONTRACT--SITE CHANNELING AGENCY

Phase I,	Task 1	$ -0-
	Task 2	$ -0-
	Task 3	$ 93,282
	Task 4	$ 207,016
Phase II,	Year 3	$ 227,717
	Year 4	$ 250,489
Phase III		$ 223,186
		$1,001,690

ITEM: SPECIAL TESTING--TASK 5--SERVICE EXPANSION

Phase I	$ 250,000
Phase II	$ 575,000
Phase III	$ 225,000
	$1,050,000

ITEM: OTHER DIRECT COSTS

Phase I, Task 1	$	1,080
Task 2	$	337
Task 3	$	580
Task 4	$	2,200
Phase II,Year 3	$	2,420
Year 4	$	2,662
Phase III	$	2,928
	$	12,207

ITEM: CONSULTANTS--SRS TECHNICAL CONSULTANT

Phase I, Task 1	$	32,529
Task 2	$	37,500
Task 3	$	4,327
Task 4	$	12,115
Phase II,Year 3	$	12,721
Year 4	$	13,357
Phase III	$	14,025
	$	126,574

ITEM: CONSULTANTS--MONTANA FOUNDATION FOR MEDICAL CARE AUDIT AND SERVICES REVIEW

Phase I, Task 1	$	-0-
Task 2	$	-0-
Task 3	$	-0-
Task 4	$	9,399
Phase II,Year 3	$	10,339
Year 4	$	11,373
Phase III	$	12,510
	$	43,621

Beginning on the next page is detail supporting each cost item, grouped by Task.

MONTANA CHANNELING DEMONSTRATION -- ITEM DETAIL

PHASE I, TASK 1: LTC PLANNING (54% of Year 1)

STATE OFFICE

Direct Labor:	SRS Manager IV $17,684 x .54 =	$ 9,549
	SRS Secretary II (½) $4,873 x .54=	2,631
		12,180
Fringes @ 17.623% x 12,180 =		2,146
Labor Overhead--	HEW approved cost allocation plan for SRS centralized services, est. $5,000 x .54=	2,700
Other Direct Costs:	Supplies 500 x .54=	270
	Public Information 1,000 x .54=	540
	Equipment 500 x .54=	270
		1,080
Travel--none		
Consultant--	@ $75,000/260= $288.46/day	
	50 days x $288.46=	14,423
		$32,529

Phase I, Task 2; Site Planning (17% of Year 1)

STATE OFFICE

Direct Labor:	SRS Manager IV x 17%=	$ 2,947
	SRS Secretary II x 17%=	812
		3,759
Fringes @ 17.623 x 3,759=		662
Labor Overhead--$5,000 x .17=		850
Other Direct Costs x 17%		337
Travel:	SRS Manager--to Missoula	
	6 trips x 240 miles x .18=	259
	x 21 room x 2 nights=	252
	x 10 per diem x 3 days=	180
	SRS Manager--to Anaconda	
	6 trips x 162 miles x .18=	175
	x 21 room x 2 nights =	252
	x 10 per diem x 3 days=	180
	Ten-member LTC Planning Group	
	To Missoula Public Forum	
	10 x 240 miles .18 x .3=	130
	x 12 per diem=	120
	To Anaconda Public Forum	
	10 x 162 miles x .18 x .3=	87
	x 12 per diem =	120
		1,755

Consultant 130 days x $288.46=	$37,500
	$44,863

PHASE I, TASK 3: SITE DEVELOPMENT (29% of Year 1)

STATE OFFICE

Direct Labor:	SRS Manager IV x 29%=	$ 5,128
	SRS Secretary II(½) x 29%=	1,413
		6,541
Fringes @ 17.623% x 6,541=		1,153
Labor Overhead--$5,000 x .29=		1,450
Other Direct Cost x 29%=		580
Travel:	SRS Manager--to Washington D.C.	
	2 trips x $750=	1,500
	SRS Manager--to Site	
	5 trips x 200 miles x .18=	180
	x 21 room=	105
	x 10 per diem x 2 days =	100
		1,885
Consultant--15 days x $288.46=		4,327
	Subtotal	15,936

SUBCONTRACT--SITE

Direct Labor:	Site Manager $68.02/day x 165=	$11,223
	Site Secretary $37.48/day x 160=	5,997
	Screener $37.48/day x 20=	750
	A/M Team $56.78/day x 110=	6,246
		24,216
Fringes @ 17.623 x 24,216=		4,268
Other Direct Cost:	Supplies	9,800
	Rent 12,000 x .89=	10,700
	Office Equipment	15,500
	Postage	1,200
	Telephone	5,800
	Insurance	2,500
	Accounting and Legal	5,300
	Audit and Bonding	3,000
	Dues and Subscriptions	750
	Board Expenses	1,800
	Staff Reqruitment	1,400
	Forms and Materials Printing	3,600
	Public Information	1,200
		62,550
Consultant--Medical		500

Travel:	Site Manager--to Washington D.C.		
	2 trips x 750=		$ 1,500
	Site Manager--to Helena		
	4 trips x 200miles x .18=		144
	x 21 room=		84
	x 10 per diem x 2 days=		20
			1,748
		Subtotal	$93,282
		Total	$109,218

PHASE I, TASK 4: IMPLEMENT CHANNELING: YEAR 2

STATE OFFICE

Direct Labor:	SRS Manager IV 17,684 x 1.10=	$19,452
	SRS Secretary II (½) 4,873 x 1.10=	5,360
		24,812
Fringes @ 17.623% x $24,812=		4,373
Labor Overhead--$5,000 x 1.10=		5,500
Other Direct Cost 2,000x 1.10=		2,200
Travel:	SRS Manager--to Washington D.C.	
	2 trips x 750 x 1,10=	1,650
	SRS Manager--to site	
	6 trips x 200 miles x .18 x 1,10=	238
	x 21 room x 1.10=	139
	x 10 per diem x 1.10 x 2 days=	132
		2,159
Consultant @ 75,000 x 1.05/260= $302.88/day		
	40 days x 302.88/day=	12,115
	Subtotal	$47,859
Subcontract--Montana Foundation @ 72.30 /day x 130=		9,399

SUBCONTRACT--SITE

Direct Labor:	Site Manager $68.02 x 1.10 x 260 =	$19,454
	Site Secretary $37.48 x 1.10 x 260=	10,719
	Screener $37.48 x 1.10 x 260=	10,719
	A/M Team $56.78 x 1.10 x 1300=	81,195
		122,087
Fringes @ 17.623% x 122,087=		21,515
Other Direct Cost:	Supplies	5,000
	Rent	12,000

Office Equipment	500
Postage	1,200
Telephone	5,800
Insurance	2,500
Accounting & Legal	5,300
Audit & Bonding	3,000
Dues & Subscriptions	750
Board Expenses	1,800
Forms, Materials, Printing	3,600
Public Information	1,200
	50,200

Consultant--Medical 4,800

Travel:

Site Manager--to Washington D.C.	
2 trips x 750 x 1.10=	1,650
Site Manager--to Helena	
4 trips x 200 miles x .18 x 1.10=	158
x 21 room x 1.10=	92
x 10 per diem x 1.10 x 2 days=	88
A/M Team and Screener	
30% of 400 clients live at a distance requiring 150miles round trip for visit; two clients per trip = 18,000 miles x .18 x 1.10 =	3,564
2 people x 120 x 10 per diem x 1.10=	2,640
70% of 400 clients are local travel, requiring 2 miles a trip, twice a year or 1120 miles x .18 x 1.10=	222
	8,414

Subtotal	$207,016
Total	$264,274

PHASE II, YEAR 3

STATE OFFICE

Direct Labor: Year 2 x 1.10=	$27,293
Fringes @ 17.623 x 27,293=	4,810
Labor Overhead-- Year 2 x 1.10=	6,050
Other Direct Cost-- Year 2 x 1.10=	2,420
Travel-- Year 2 x 1.10=	2,375
Consultant -- Year 2 x 1.05=	12,721
Subcontract--Montana Foundation--Year 2 x 1.10=	10.339

SUBCONTRACT--SITE Year 2 x 1.10=		$227,717
	Total	$293,725

PHASE II, YEAR 4

STATE OFFICE		
Direct Labor: Year 3 x 1.10=		$30,022
Fringes @ 17.623=		5,291
Labor Overhead-- Year 3 x 1.10 =		6,655
Other Direct Cost -- Year 3 x 1.10=		2,662
Travel-- Year 3 x 1.10=		2,613
Consultant -- Year 3 x 1.05 =		13,357
Subcontract--Montana Foundation--Year 3 x 1.10=		11,373
SUBCONTRACT--SITE Year 3 x 1.10=		250,489
	Total	322,462

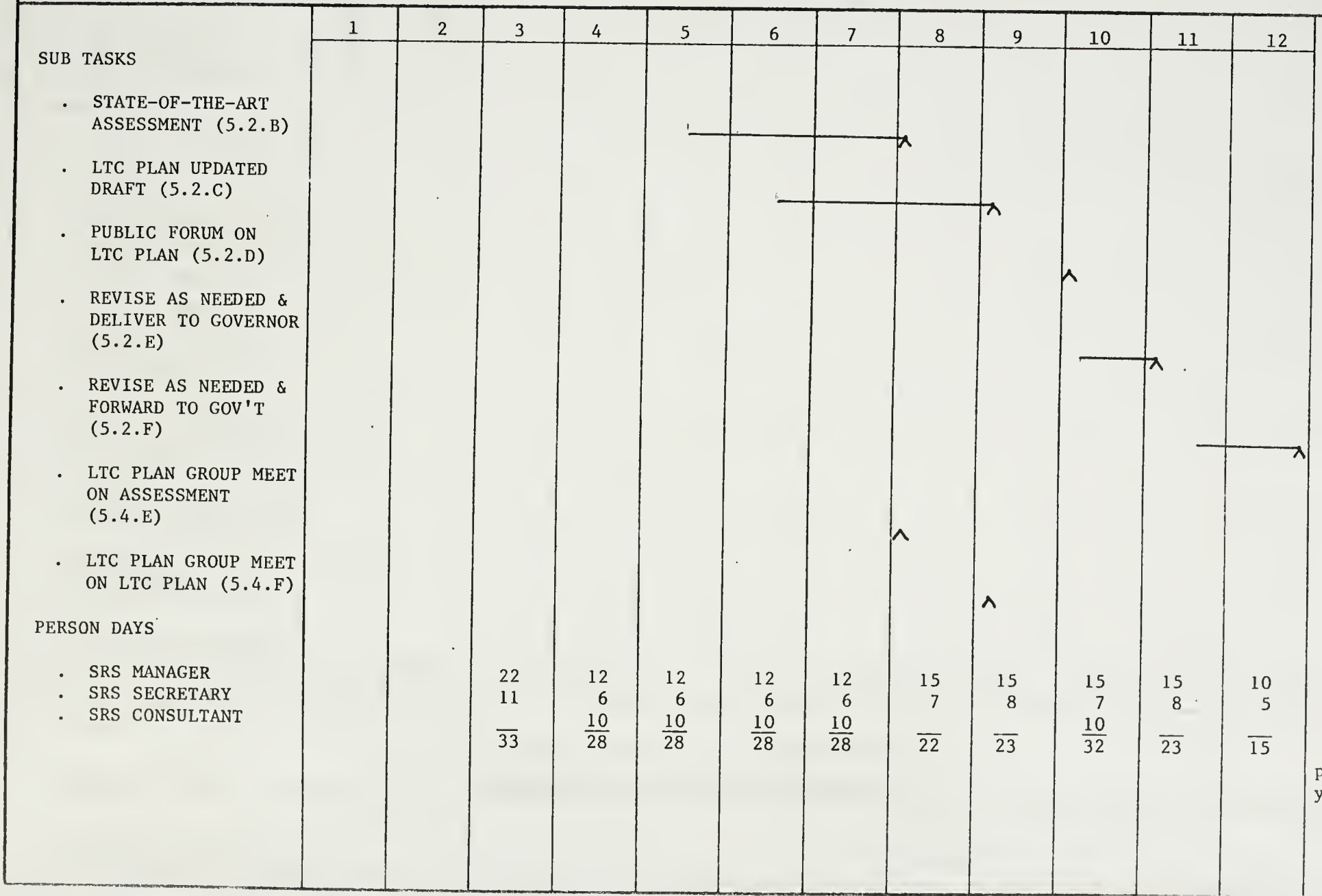
PHASE III, YEAR 5

STATE OFFICE		
Direct Labor: Year 4 x 1.10 =		$ 33,024
Fringes @ 17.623 =		5,820
Labor Overhead -- Year 4 x 1.10 =		7,321
Other Direct Cost -- Year 4 x 1.10 =		2,928
Travel -- Year 4 x 1.10 =		2,874
Consultant -- Year 4 x 1.05 =		14,025
Subcontract--Montana Foundation--Year 3 x 1.10=		12,510
SUBCONTRACT--SITE Year 4 x .81 x 1.10 =		223,186
	Total	301,688

BEGINNING ON THE NEXT PAGE are time charts for each task and the person hour allocations that relate to the charts. The number in parentheses after each subtask references that subtask in the technical proposal in Section 6.1.

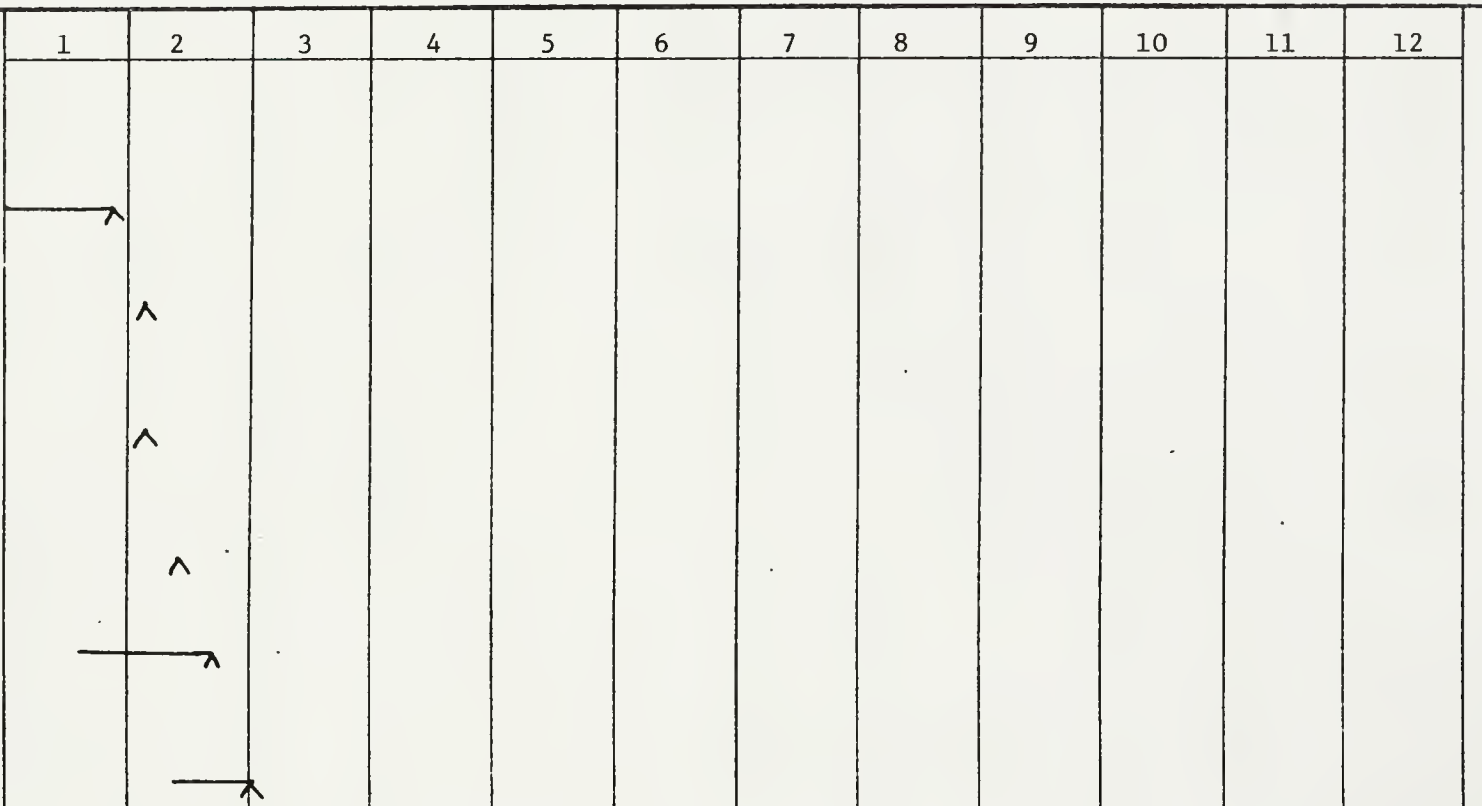
MONTANA CHANNELING DEMONSTRATION

PHASE I, TASK 1: LTC PLANNING: YEAR 1



MONTANA CHANNELING DEMONSTRATION

PHASE I, TASK 2: SITE PLANNING: YEAR 1



SUBTASKS

- . DRAFT REPORT - TWO SITES (6.1)
- . LTC PLAN GROUP DRAFT REPORTS (6.2)
- . PUBLIC FORUM - ANACONDA SITE PLAN (6.2)
- . PUBLIC FORUM - MISSOULA SITE PLAN (6.3)
- . PREPARE PROPOSED SUBCONTRACTS (6.4)
- . SITE REPORTS & CONTRACTS TO GOV'T (6.5)

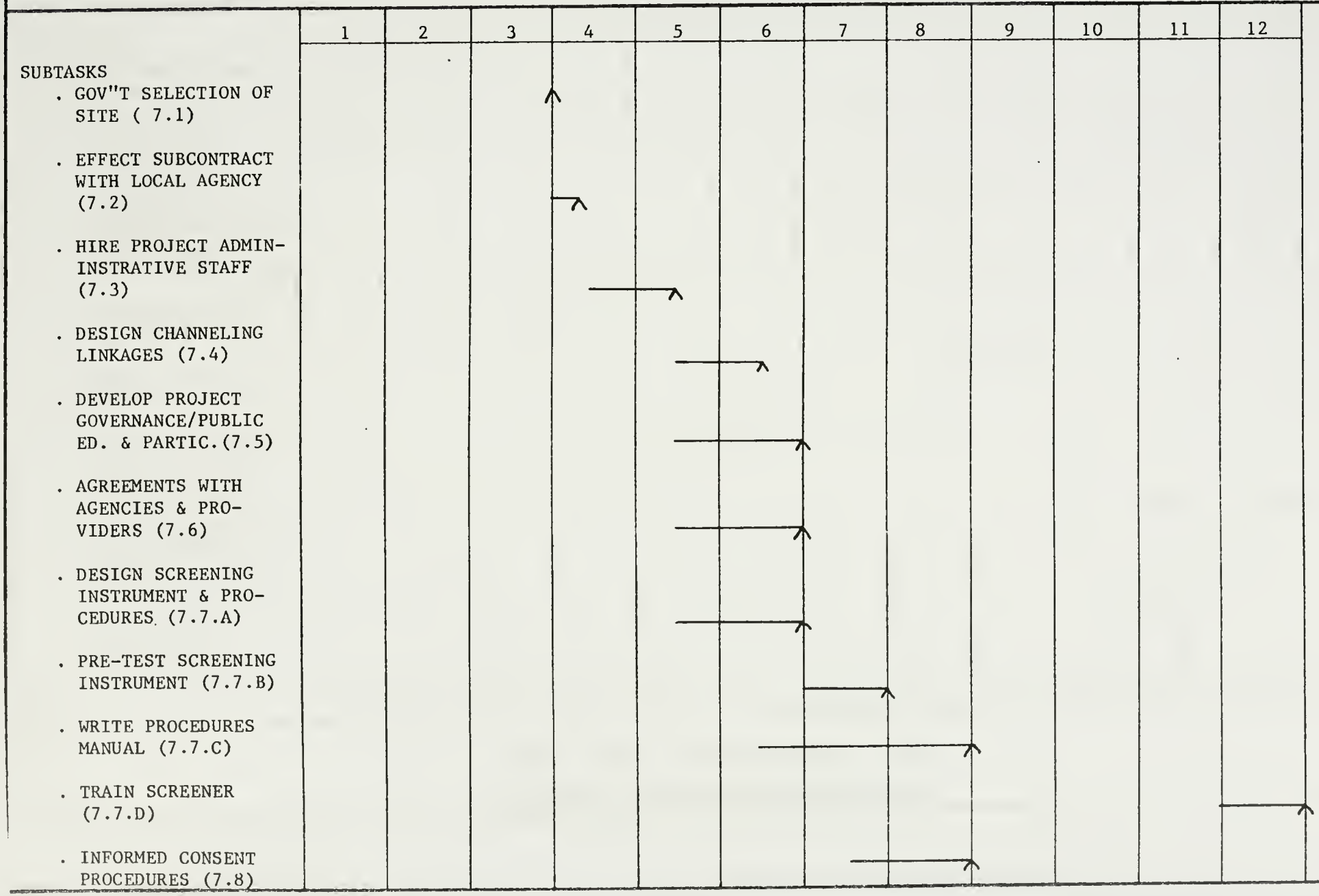
PERSON DAYS

. SRS MANAGER	21	22
. SRS SECRETARY	11	11
. SRS CONSULTANT	78	52
	110	85

0.75 person years

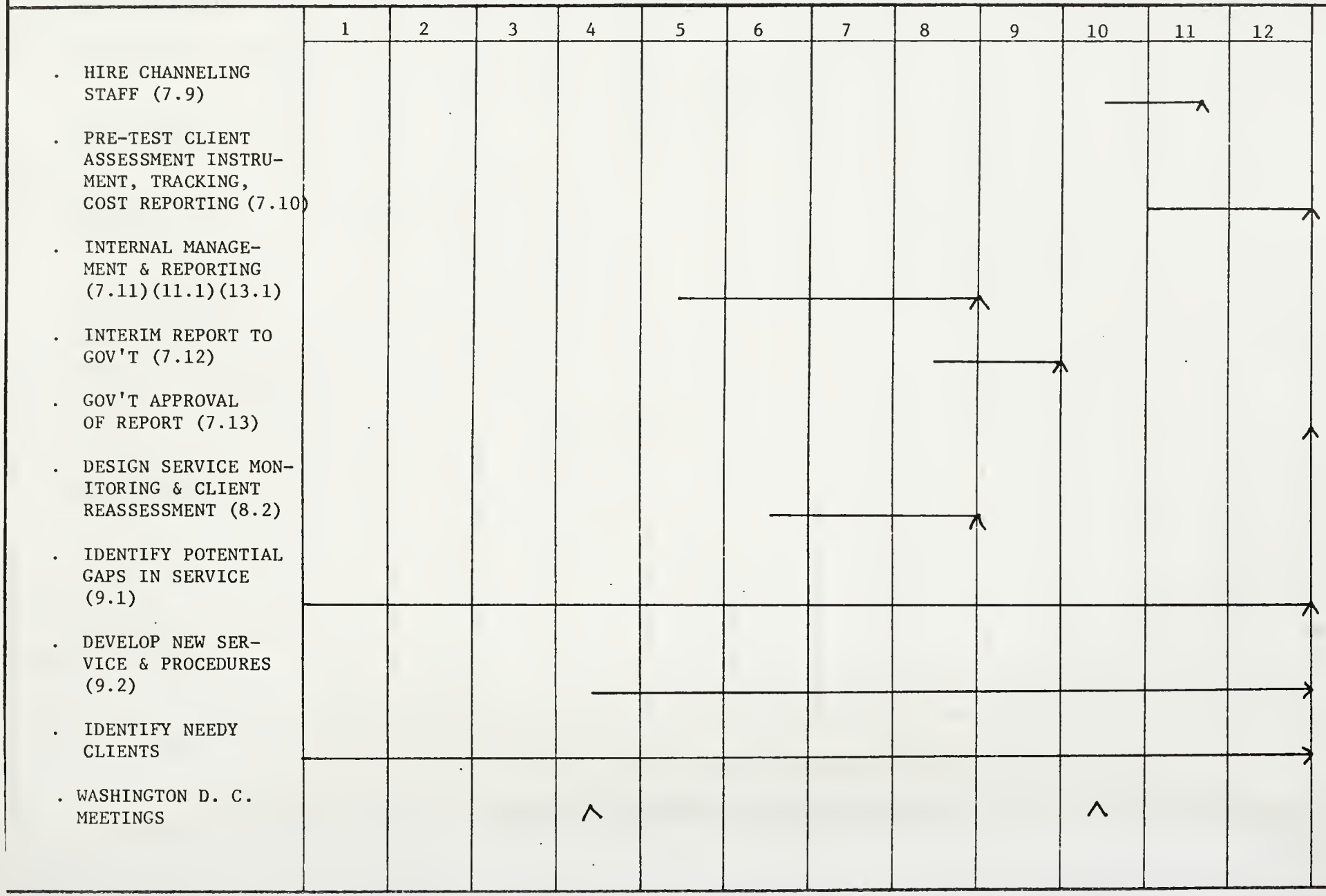
MONTANA CHANNELING DEMONSTRATION

PHASE I, TASK 3: SITE DEVELOPMENT: YEAR 1



MONTANA CHANNELING DEMONSTRATION

PHASE I, TASK 3: SITE DEVELOPMENT: YEAR 1



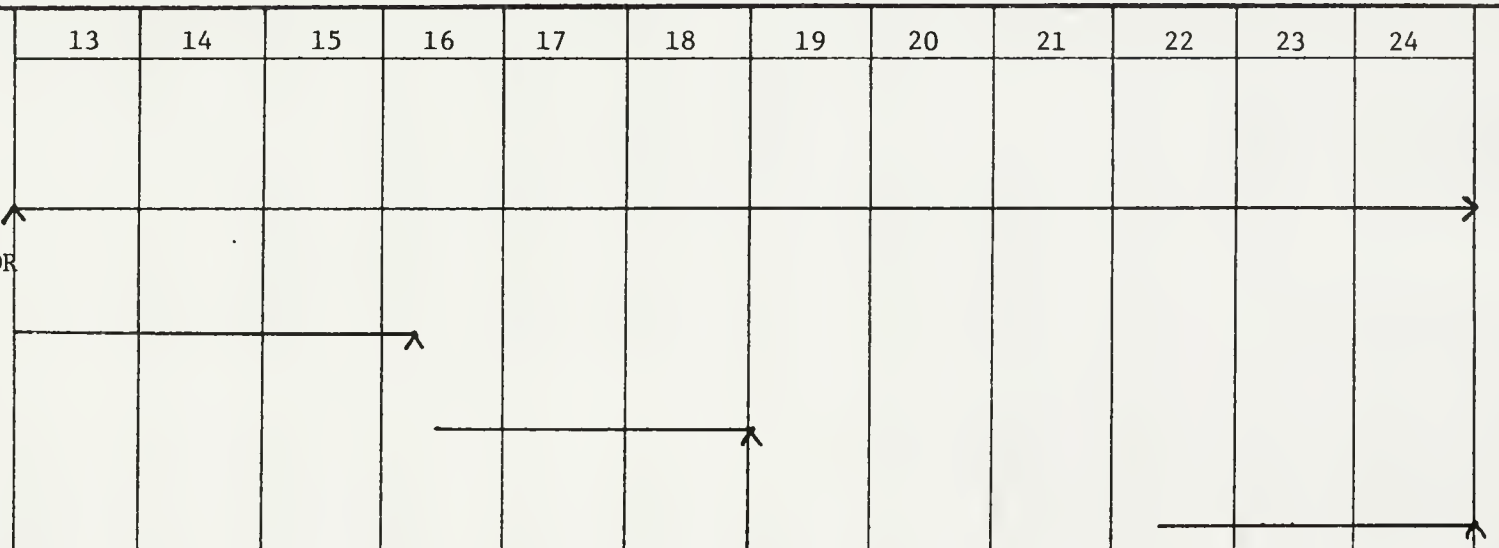
MONTANA CHANNELING DEMONSTRATION

PHASE I, TASK 3: SITE DEVELOPMENT: YEAR 1

	1	2	3	4	5	6	7	8	9	10	11	12	
PERSON DAYS													
. SRS MANAGER				10	10	10	10	7	6	7	7	10	
. SRS SECRETARY				5	5	5	5	4	3	3	3	5	
. SRS CONSULTANT					3	3	3	3				3	
. SITE MANAGER					11	22	22	22	22	22	22	22	
. SITE SECRETARY					6	22	22	22	22	22	22	22	
. SCREENER												20	
. A/M TEAM												110	
				15	35	62	62	58	53	54	54	192	2.25 person years

MONTANA CHANNELING DEMONSTRATION

PHASE I, TASK 4: IMPLEMENT CHANNELING: YEAR 2



	13	14	15	16	17	18	19	20	21	22	23	24
SUBTASKS												
. INITIATE CHANNELING SERVICE (8.1)												
. DESIGN & ARRANGE FOR AUDIT & PROGRAM REVIEW (8.3)												
. CONDUCT REVIEW & REPORT # 1 (8.4)												
. CONDUCT REVIEW & REPORT # 2 (8.5)												
. NOTICE OF WAIVER SCOPE (12.1)												
. INTERIM REPORT/ PHASE II PLAN (12.2)												
. WASHINGTON D.C. MEETINGS												
PERSON DAYS												
. SRS MANAGER	22	22	21	22	21	22	21	22	22	21	22	22
. SRS SECRETARY	11	11	11	11	10	11	11	11	11	10	11	11
. SRS CONSULTANT							10	10			10	10
. SITE MANAGER	22	22	21	22	21	22	21	22	22	21	22	22
. SITE SECRETARY	22	22	21	22	21	22	21	22	22	21	22	22
. SCREENER	22	22	21	22	21	22	21	22	22	21	22	22
. A/M TEAM	110	110	105	110	105	110	105	110	110	105	110	110
. MONTANA FOUNDATION	16	16	16	16	16	16				2	16	16
	225	225	216	225	216	225	210	219	209	201	235	235

10.15 person years

MONTANA CHANNELING DEMONSTRATION

PHASE II - YEAR 3

	25	26	27	28	29	30	31	32	33	34	35	36	
SUBTASKS													
. CONTINUE CHANNELING SERVICE (14.)												→	
. WASHINGTON D.C. MEETINGS (15.)	^						^						
. SEMI-ANNUAL AUDIT/ REVIEWS (8.3)				—	—	^							
. AUDIT/REVIEW; 3RD ANNUAL REPORT (16.2)										—	—	^	
PERSON DAYS													
. SRS MANAGER	22	22	21	22	21	22	21	22	22	21	22	22	
. SRS SECRETARY	11	11	11	11	10	11	11	11	11	10	11	11	
. SRS CONSULTANT					10	10					10	10	
. SITE MANAGER	22	22	21	22	21	22	21	22	22	21	22	22	
. SITE SECRETARY	22	22	21	22	21	22	21	22	22	21	22	22	
. SCREENER	22	22	21	22	21	22	21	22	22	21	22	22	
. A/M TEAM	110	110	105	110	105	110	105	110	110	105	110	110	
. MONTANA FOUNDATION				13	26	26				13	26	26	
	209	209	200	222	235	245	200	209	209	212	245	245	10.15 person years

MONTANA CHANNELING DEMONSTRATION

PHASE II - YEAR 4

	37	38	39	40	41	42	43	44	45	46	47	48
SUBTASKS												
. CONTINUE CHANNELING SERVICES (14.)	———	———	———	———	———	———	———	———	———	———	———	——→
. WASHINGTON D.C. MEETINGS (15.)	^						^					
. SEMI-ANNUAL AUDIT/ REVIEW (8.3)				———	———	——↑						
. AUDIT/REVIEW; 4TH ANNUAL REPORT (16.4)										———	———	——↑
. SUBMIT PHASE III PLAN (16.1)						———	———	——↑				
. GOV'T DECISION ON PHASE III (16.2)												↑
PERSON DAYS												
. SRS MANAGER	22	22	21	22	21	22	21	22	22	21	22	22
. SRS SECRETARY	11	11	11	11	10	11	11	11	11	10	11	11
. SRS CONSULTANT					10	10					10	10
. SITE MANAGER	22	22	21	22	21	22	21	22	22	21	22	22
. SITE SECRETARY	22	22	21	22	21	22	21	22	22	21	22	22
. SCREENER	22	22	21	22	21	22	21	22	22	21	22	22
. A/M TEAM	110	110	105	110	105	110	105	110	110	105	110	110
. MONTANA FOUNDATION				13	26	26				13	26	26
	209	209	200	222	235	245	200	209	209	212	245	245

10.15 person years

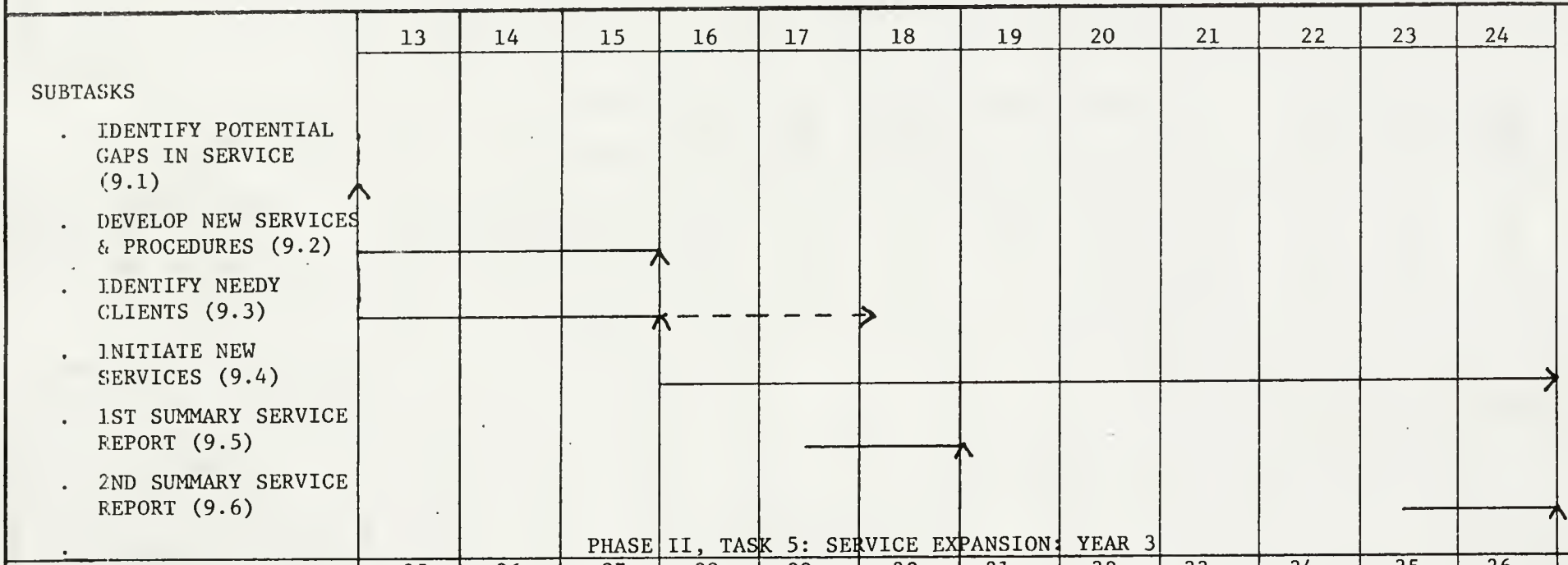
MONTANA CHANNELING DEMONSTRATION

PHASE III - YEAR 5

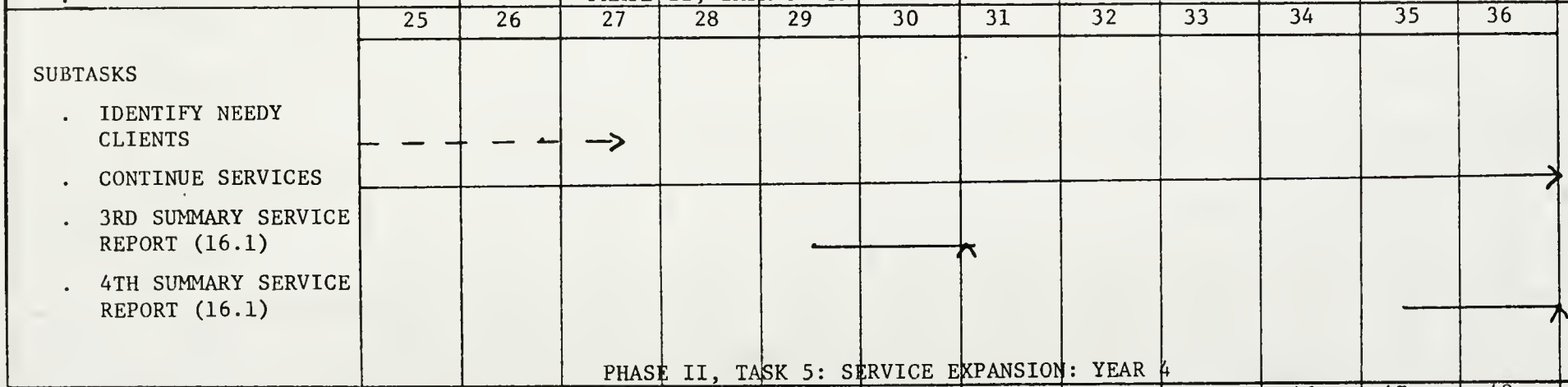
	49	50	51	52	53	54	55	56	57	58	59	60	
SUBTASKS													
. CONTINUE CHANNELING SERVICE (6.1.17)													
. WASHINGTON D.C. MEETINGS (18.1)	^												
. SEMI-ANNUAL AUDIT/ REVIEW (8.3)													
. AUDIT/REVIEW; FINAL REPORT (6.1.19)													
PERSON DAYS													
. SRS MANAGER	22	22	21	22	21	22	21	22	22	21	22	22	
. SRS SECRETARY	11	11	11	11	10	11	11	11	11	10	11	11	
. SRS CONSULTANT					10	10					10	10	
. SITE MANAGER	22	22	21	22	21	22	21	22	22	21	22	22	
. SITE SECRETARY	22	22	21	22	21	22	21	22	22	21	22	22	
. SCREENER													
. A/M TEAM	110	110	105	110	105	110	105	110	110	46	22	22	
. MONTANA FOUNDATION				13	26	26				13	26	26	
	187	187	179	200	214	223	179	187	187	132	135	135	8.25 person years

MONTANA CHANNELING DEMONSTRATION

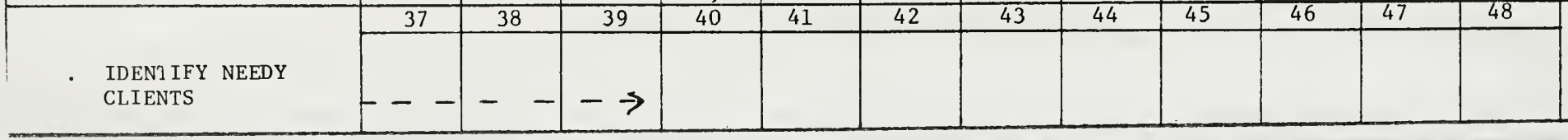
PHASE I, TASK 5: SERVICE EXPANSION: YEAR 2



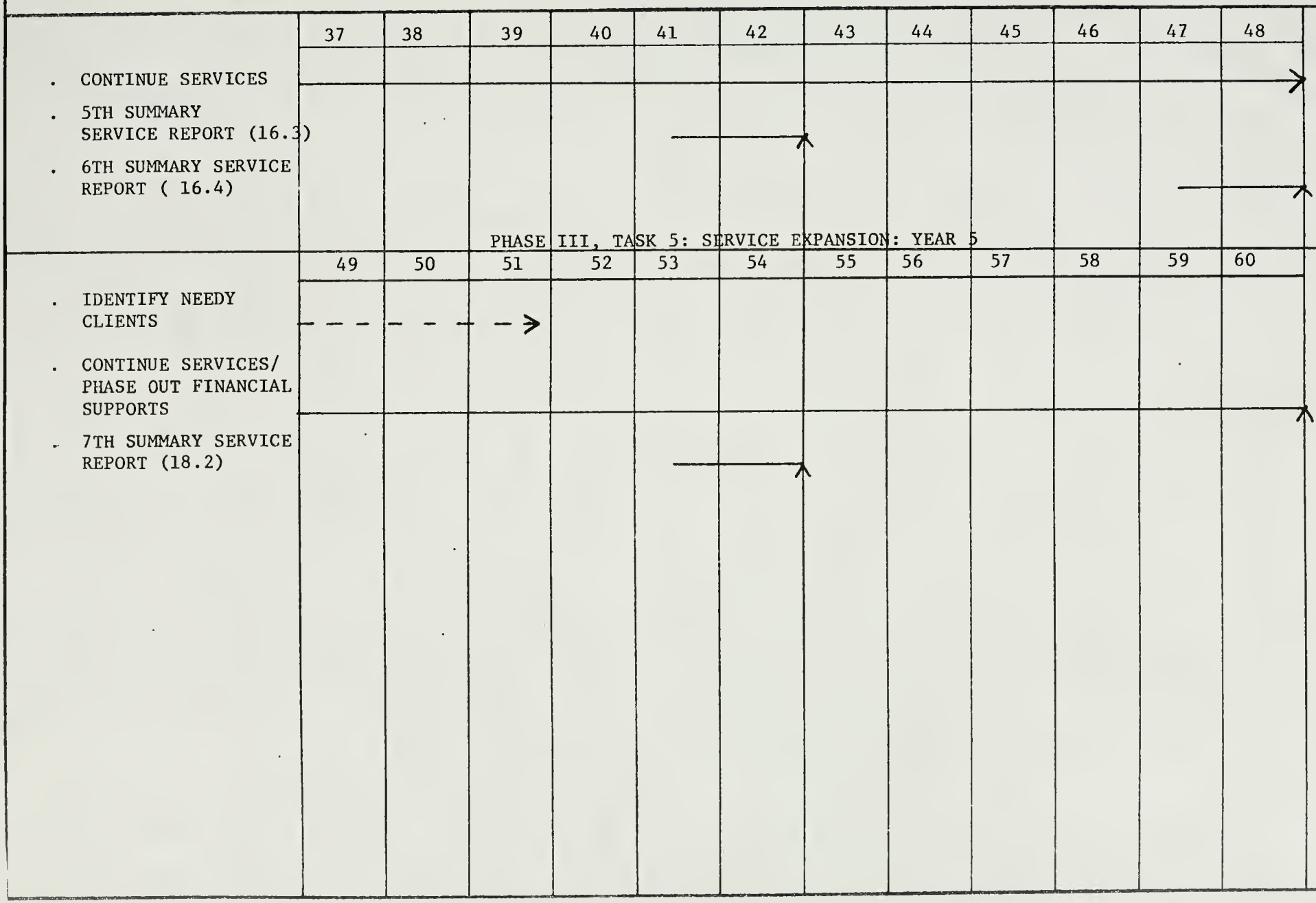
PHASE II, TASK 5: SERVICE EXPANSION: YEAR 3



PHASE II, TASK 5: SERVICE EXPANSION: YEAR 4



MONTANA CHANNELING DEMONSTRATION



MONTANA

ALTERNATE BUSINESS PROPOSAL

In support of the alternate addressed in the technical proposal, this alternate business proposal is offered. All services proposed in response to the RFP are to be performed. For an additional $300,000 the offeror will contract with a qualified consulting firm to conduct a survey of Montana elderly who had been previously surveyed between January 1980 and May 1980, using the Geriatric Functional Rating Scale GFRS, developed by Grauer and Birnbom. The initial follow-up survey would be conducted 18 months following the original, and would target on the 1000 respondents who were randomly selected without reference to institutional conditions. This initial survey and report will be used to validate the prediction capability of the instrument for this set of respondents at a price of $75,000 involving one (1) person year of consulting time. For each of the succeeding years the same set of respondents will be followed and surveyed with the GFRS and a report of results prepared. Each of the three succeeding surveys and reports will be conducted and prepared at a price of $75,000 involving one (1) person year.